

**COMMUNITY MENTAL HEALTH TEAM MEMBERS' PERCEPTIONS OF
TEAM FORMULATION IN PRACTICE**

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Thesis Abstract

OBJECTIVES

Team formulation is expected to support multidisciplinary team members to work effectively with their clients, meet their clients' needs and broaden their psychological knowledge. There remains a lack of research evidence regarding the perceptions of team formulation among Community Mental Health Team (CMHT) members. This study addressed the following research questions; (1) what are considered helpful or unhelpful aspects of team formulation? (2) what are the processes or mechanisms that lead to unhelpful or helpful aspects of team formulation? (3) what is the impact of team formulation on professionals' clinical practice? and (4) what are the factors that may influence these outcomes?

DESIGN

An inductive qualitative design was used, utilising a contextualist, critical-realist paradigm.

METHODS

12 CMHT members who attended team formulation were recruited from three sites within the British National Health Service. In each site, an individual interview with a clinical psychologist and a focus group with three professionals were conducted. An inductive thematic analysis was used.

RESULTS

Attendees across the three teams reported that although team formulation was optional, a low priority and outside of their usual way of working, this was engaged by those who perceived a value in it. Participants reported that this process required a safe environment which would not threaten attendees' job securities; and identified factors that enable this. Although attendees predominately reported helpful aspects of engaging in team formulation, these could also be perceived as unhelpful (apart from validation). The helpful aspects of team formulation involved other professionals' contributions. Attendees reported that team formulation impacted on their clinical practice by (1)

providing alternative ways of working with clients and meeting their clients' needs and (2) justifying discontinuation of clinical work.

Across all teams, participants reported that ideas derived from team formulation, integrated into care plans (CPs) were integral and that these CPs were valued outcomes/ products of team formulation. Participants reported that CPs were helpful in justifying attendees' engagement in team formulation, prioritising ideas and making these achievable, and providing a rationale for professionals to flexibly test ideas. Participants did not report unhelpful aspects of CPs as products of team formulation. There were conflicting perceptions across the teams regarding the factors that influenced the use of CPs e.g., psychologists expected CPs to be used but also reported that this was not required as attendees adopted alternative perspectives.

CONCLUSIONS

This study found that attendees reported that other professionals' contributions enabled them to work effectively with their clients and meet their clients' needs. Attendees did not outline broadening their psychological knowledge as suggested by the professional document published by the Division of Clinical Psychology (2011). This study's findings suggests that each CMHT may benefit from discussing (1) clear expectations of team formulation, as this process can be perceived as different for attendees, (2) what aspects enable team formulation to be safe and ascertain how this could be achieved, (3) the unhelpful aspects of engaging in team formulation and ways of managing these, and (4) agreeing on their expectations of the outcomes or use of the products of team formulation i.e., are professionals expected to use CPs, adopt alternative perspectives, or both. If CPs are expected to be utilised then CMHTs may require support from their managers.

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STATEMENT OF CONTRIBUTION

Tinemakomboreroashe Blee was responsible for the design of this project, applying for ethical approval, reviewing relevant literature, recruitment of participants, data collection, transcription, analysis and writing up the research.

Dr Michael Rennoldson and Dr Danielle De Boos provided supervision and guidance throughout the research process. They were also responsible for independently coding two transcripts, reviewing themes, reviewing the thematic maps and tables that was derived from the analysis and checking through drafts of the write up.

Dr Sharron Smith provided advice and guidance throughout the research process. She also provided constructive feedback on the write up of the research. She was also responsible for providing links to other clinical psychologists who may be interested in participating in the study. A number of unnamed professionals were also responsible for disseminating the Participant information sheets within their teams.

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SYSTEMATIC LITERATURE REVIEW

Impact of psychological formulations shared amongst non-psychology staff members: A systematic literature review

Clinical psychology professional documents indicate that non-psychology staff members have reported benefits of shared psychological formulations. This review aimed to undertake an in-depth examination of this.

A systematic search of articles in sources of published and unpublished research was completed. The inclusion criteria did not outline any limits relating to the studies' research methodologies; however participants had to be non-psychology staff members, who had experienced shared psychological formulations based on existing clients. Nine articles were identified.

Methodological shortcomings were identified in the articles regarding (1) the research designs, (2) researchers' and participants' understanding of the phenomenon outlined in the studies, (3) data collection and analysis and (4) sampling methods. Narrative synthesis was used to summarise the findings found in the articles. It was found that some of the studies explored other aspects relating to shared psychological formulations such as the meeting itself, therefore findings relating to shared psychological formulations had to be extracted from the articles. A limited amount of evidence regarding the impact of shared formulations was found.

Limited evidence regarding the impact of shared psychological formulations amongst non-psychology staff members was found. Practice and research recommendations have been outlined, particularly regarding improving the methodological quality of future research.

A psychological formulation is defined as an explanation of a client's presenting problem, outlining the development and maintenance process (Division of Clinical Psychology [DCP], 2010, 2011). Clinical psychologists are expected to integrate psychological theory and research evidence to inform this explanation (DCP, 2010, 2011). The understanding gained from this explanation is expected to facilitate identification of appropriate interventions (DCP, 2010, 2011). It is acknowledged within the clinical psychology field that there is no universally agreed definition of what constitutes a psychological formulation. This does not appear to have deterred clinical psychologists in developing and sharing formulations with their colleagues (Berry, 2007; Jackman, 2013; Lake, 2008; Preedy, 2008). Literature indicates that sharing psychological formulations amongst staff members is becoming common practice within clinical psychologists' roles (DCP, 2011; Skinner & Toogood, 2010).

Research has shown that clinical psychologists share psychological formulations amongst their colleagues in a range of settings, using a variety of strategies (Onyett, 2007). Clinical psychologists are reported to share psychological formulations during team meetings, ward rounds and reflective practice groups (Onyett, 2007). Psychological formulations are either presented informally, whereby hypotheses are stated as part of a conversation (Christofides, Johnstone, & Musa, 2012) or

explicitly, with the use of formal structured case presentations (Whomsley, 2010). The presentation style which the clinical psychologist adopts is dependent on the team culture, the relationship he or she has with team members (Christofides et al, 2012) and the service's expectations of the psychologist's role (Preedy, 2008; Shirley, 2010; Whomsley, 2010). The majority of studies regarding shared psychological formulations amongst multi-disciplinary teams have outlined psychological models and frameworks that have been used successfully by clinical psychologists (Davenport, 2002; Jackman, 2013; Martindale, 2007; Rowe & Nevin, 2013; Shirley, 2010). Bieling and Kuyken (2003) outline that although this information is useful for clinical psychologists, the focus should be on the value of this practice.

Professional documents within the clinical psychology field have outlined the benefits of sharing psychological formulations with non-psychology¹ staff members. The *Good Practice Guidelines on the use of Psychological Formulation* has cited articles that report benefits of shared psychological formulations amongst multi-disciplinary team members (DCP, 2011). It is reported that shared formulations provide a shared understanding of the client's difficulties, which leads to "increased staff morale, generation of new ways of thinking

¹ For the purposes of this review, non-psychology staff members exclude qualified and unqualified psychologists such as clinical, trainee and assistant psychologists. Therefore, non-psychology staff members would include staff members from other disciplines.

and a consistent team approach to an intervention” (DCP, 2011, p. 9). *The Core Purpose and Philosophy of the Profession* document has suggested that sharing psychological formulations can assist non-psychology staff members to develop “psychologically- informed ways of thinking” (DCP, 2010, p. 4). In consideration of the reports outlined in these professional documents, this review aimed to undertake an in-depth analysis of the evidence regarding the impact of psychological formulations. An evaluation of this literature could assist in understanding the value of clinical psychologists’ practice, offer guidance for future research and identify areas of importance for future practice.

This systematic literature review aimed to answer the following question:

What are the benefits and disadvantages reported by non-psychology staff members regarding psychological formulations shared by clinical psychologists, during multi-disciplinary meetings?

Reviewer’s Epistemological Stance

Prior to undertaking the systematic literature review, the primary researcher adopted a critical realist epistemological position. She acknowledged that the findings from the articles retrieved may provide an insight into the reality of the staff members’ experience; however each participant’s reports may

be influenced by environmental factors (Blanketz, 1998; Harper, 2012). It is recognised that the articles may provide a secondary-level interpretation of the primary data collected and these interpretations may be influenced by the researchers' own lived experiences and epistemological stances. In this review an in-depth analysis of the evidence was undertaken whilst acknowledging the studies' environmental factors.

Methods

For the purpose of this review, a *priori* inclusion criteria were defined.

- Articles were included in the review if they were written in English language.
- Study participants had to be non-psychology staff members who had experienced formulations shared amongst other professionals. This criterion was included as a large proportion of literature on this topic is descriptive outlining opinions and expectations of shared psychological formulations.
- Shared psychological formulations had to be based on existing clients rather than vignettes. It was assumed that if staff members had a working relationship with an existing client they may be able to explore complex aspects of the client's presenting behaviour. However, this may be inhibited with the use of vignettes (Hughes

& Huby, 2002). This review was interested on the impact of shared formulations and it was assumed that the use of existing clients' formulations may strengthen the validity of these findings.

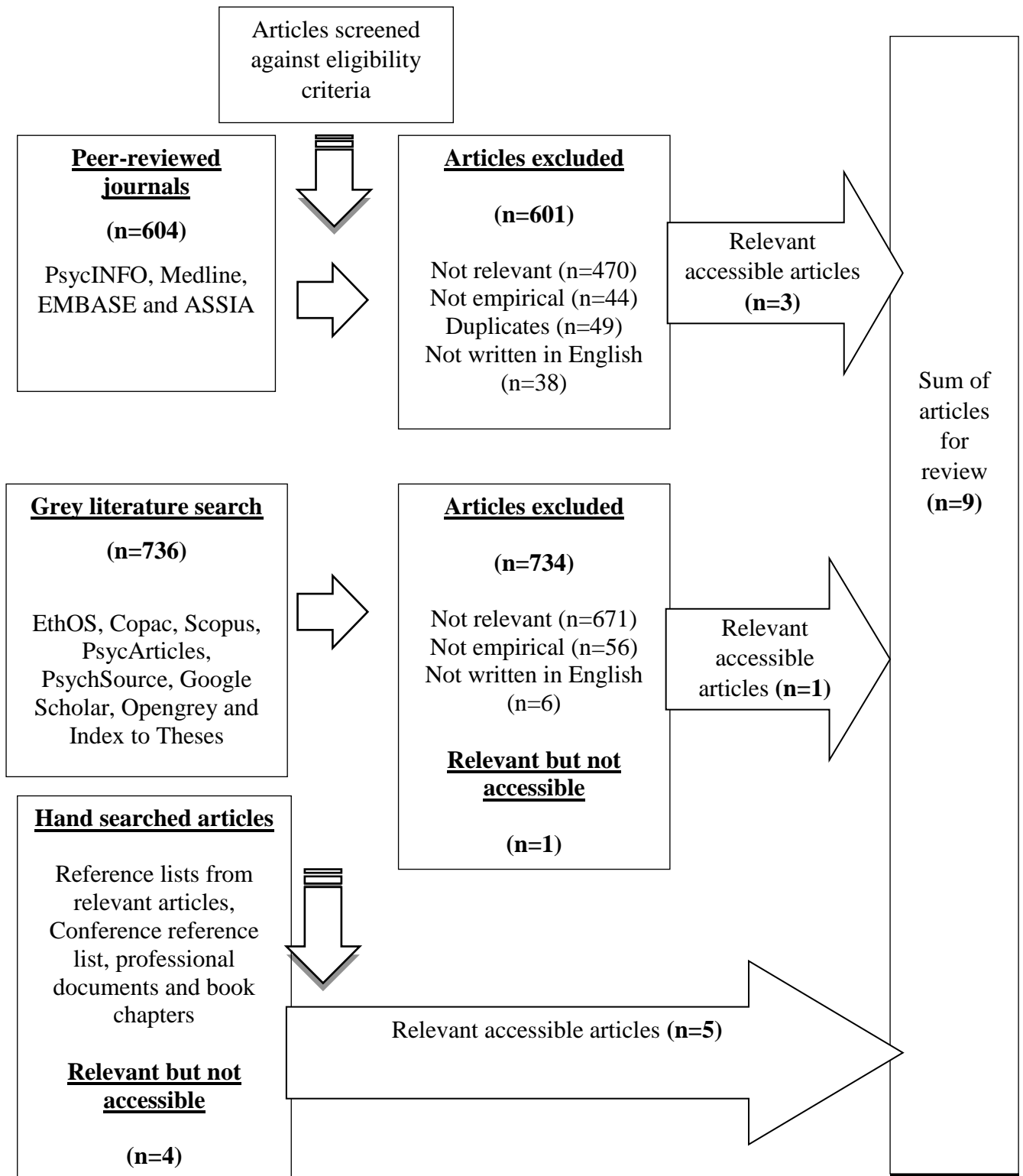
Systematic Literature Review Search

During the construction of the review question and initial scoping searches, it was found that some of the cited articles in the professional clinical psychology documents were not found in peer-reviewed journals. Therefore, a broad search of articles was completed in databases of published and unpublished (grey) research in order to minimise publication bias (Rothstein & Hopewell, 2009; The Joanna Briggs Institute, 2008). The search strategy, which outlines how the articles were retrieved, has been presented in Figure 1. In total nine relevant articles were retrieved for this review; three from peer-reviewed journals, one from the grey literature search² and five through hand searching.

² Although initial scoping suggested that relevant articles might be found in the grey literature, only one (obtainable) article met inclusion criteria for the review.

Figure 1

Search Strategy



Note. n= sum of articles

Keywords and search terms.

A range of search terms were used to enable a broad search of articles to answer the review question (Table 1 and 2). The search terms included “psychological formulation”, “case conceptualisation”, “case formulation”, “team”, “meeting”, “staff”, “multi disciplinary”, “mental health service”, “attitude”, “hospital”, “clinical practice”, “reflective practice” and “consultation”. Some of the search terms were exploded depending on the database used e.g. “attitude” included “attitude to health/ or health personnel attitude/ or patient attitude/ or attitude to mental illness/ or employee attitude/ or attitude to change/”. A large proportion of the results was drawn from databases using truncation symbols such as ?, \$ and *, for example, “psycholog* formulat*” captured variations of this including “psychologist formulating” and “psychological formulations”. Positional operators such as ADJ were inputted within these terms to locate records where terms could be found within certain proximities e.g. “psycholog* ADJ10 formulat*” located literature with these terms found within ten-word radius. Search terms were combined using Boolean operators such as “AND” to contain all of the specified search terms and “OR” to collate records matching any of the specified search terms. The “OR” Boolean operator was also used to exclude duplicate records. The search terms

and combinations used varied depending on the database specifications, as shown in Table 1 and 2.

Search in peer-reviewed journals.

A search in peer-reviewed journals was conducted on four databases, namely PsycINFO, Medline, EMBASE and Applied Social Sciences Index and Abstracts (ASSIA) and completed in July 2013. When all the articles were obtained, each of the articles' titles and abstracts were examined against the inclusion criteria to ascertain if the article was appropriate for the review. A total of 604 articles were examined. Amongst these articles 552 did not meet the inclusion criteria, 49 were duplicates and three were found to be relevant for the review.

Parallel grey literature search.

A grey literature search was completed in July 2013. The search was undertaken on databases that collated literature from research theses and documentation from a range of UK universities, including Electronic Thesis Online Services (EThOS), Index to Theses and Copac. Further searches were conducted on databases such as Scopus, PsycARTICLES, British Psychological Society gateway (PsychSource) and Opengrey, which collectively have a broad coverage of articles relevant to psychology, social sciences and medicine. Google Scholar was used to ascertain if there were any other relevant articles not found in the previous searches. During the grey

literature search the titles of the articles were initially examined, and if accessible the abstracts were retrieved. If inadequate information was found, the full text was located (if accessible) and examined against the inclusion criteria. A total of 736 articles were examined. Amongst these articles 734 did not meet the inclusion criteria and two were found to be relevant for the review, however, only one of these could be retrieved. The reference of the article that could not be accessed due to university restrictions on availability of a service evaluation has been presented in Table 4.

Hand searching.

The reference lists of the obtained articles, professional documents and book chapters were examined (Table 3). Facilitators from an event that presented evidence for sharing psychological formulations in teams were contacted for references and any relevant articles. Authors were contacted via email to request articles that could not be found. During hand searching nine relevant articles were found, however only five of these could be accessed. The references of the four articles that could not be accessed due to university restrictions on availability of doctoral theses and unavailability of articles within databases have been presented in Table 4.

General characteristics

Information extracted from the nine articles is shown in Table 5. The aims of the studies, sample size and composition, method of data collection and analysis and key findings are outlined in this table.

Methodology quality appraisal

A quality appraisal framework developed by the UK National Centre of Social Research was chosen prior to searching for the articles for this review (Appendix A). The framework provides clear and unambiguous criteria to assess the quality of qualitative studies (Spencer, Ritchie, Lewis & Dillon, 2003; Walsh & Downe, 2006). When the framework was compared to others such as the Critical Appraisal Skills Programme, it was found that it enabled an in-depth analysis of the quality of qualitative studies (Walsh & Downe, 2006). Authors of this framework recommended that adaptations of items should be made according to the possible articles being reviewed (Spencer et al, 2003). It was acknowledged that quantitative studies may be retrieved in this review because of the inclusion criteria. Therefore items from the Newcastle-Ottawa Scale (NOS) were retrieved (Wells et al, 2009) and formed part of the adapted quality appraisal framework used in this review. In the adapted framework, a further appraisal system was created to grade any flaws detected in each of the criterion (Table 6). Grades 0 to 3 were given to each criterion

indicating: 3- when no or few flaws were found, 2- some flaws, 1- significant flaws and 0- when judged to be untrustworthy. A mean of these grades formed the overall grade of each study. This adapted quality appraisal framework provided a rigorous structure to evaluate the articles.

Results

Overview of articles

The articles varied in relation to the study aims and designs. Amongst the nine articles very few of the studies focused on the shared formulation itself [5, 6 & 8]³ as the majority explored the formulation process [1 & 7], formulation meeting [2 & 9] and formulation work [4]. Therefore, findings regarding shared psychological formulations had to be extracted from the articles. With regards to study designs, articles used descriptive [2, 4, 6, 7, 8 & 9], case study [3 & 5] and quasi-experimental designs [1]. In addition to this, two of the articles reported undertaking a service evaluation [9] or an audit [2] regarding service provision of psychological formulation work. It is acknowledged that the majority of studies did not aim to focus on the causal effects of the formulation itself but rather aimed to build an understanding of this phenomenon and other aspects related to it. Therefore, the study designs outlined in these articles may have been appropriate way of gathering this information. However, as will

³ [...] Each article has been given a reference number as shown in Table 5.

be explored in the following sections, it was difficult to ascertain the direct impact of the shared formulation itself. In the following sections the research methodologies used will be evaluated in order to ascertain the validity of the findings.

When appraising the articles in this review, methodological shortcomings were found (Table 6). Amongst the nine articles, one article was graded untrustworthy [7] four were graded as presenting with significant flaws [2, 3, 8 & 9], three were graded as presenting with some flaws [1, 4 & 5] and one was graded as having no or few flaws [6]. In relation to this, no articles were excluded from this review as it was considered that undertaking an evaluation of all the articles could assist in informing recommendations for future research.

Operationalisation of ‘Psychological Formulations’

There was a lack of consistency in how the phenomenon, psychological formulation, was defined in the articles as some aspects were not outlined by the authors. Psychological formulations were reported to be an explanation of an individual’s presenting difficulties [1, 2, 6, 8 & 9], integrating psychological theory [2 & 6], describing the development and maintenance of the client’s difficulties [5 & 9] and providing a rationale for an intervention [2 & 5]. The inconsistency in the definition of psychological formulations could impact on reaching a conclusive understanding of the

effects of this phenomenon, as it is unclear that researchers were discussing the same concept (Rosnow & Rosenthal, 2005). One article reported that participants' understanding of the phenomenon of psychological formulation was similar to that presented within the literature [4]; however the authors did not elaborate on this. A lack of evidence regarding the agreed operationalisation of psychological formulations and the congruency between the researchers' and participants' understanding of the phenomenon was found in the articles. This questions the internal validity of the studies (Matthews & Ross, 2010). In relation to this, none of the articles stated whether the formulations presented amongst the multidisciplinary meetings met expectations of the researchers or participants. It is assumed that the phenomenon investigated was agreed within the context of investigation, questioning the validity of the studies.

Operationalisation of the Expected Outcome

The articles presented variability regarding the expected outcomes of the studies. Researchers aimed to find a change in staff members' perceptions [1, 2 & 5], increase staff understanding of client's difficulties and psychological thinking [3 & 9] and gather information on the use of formulations [4]. It was found that three of the nine articles did not outline their expected outcome [6, 7 & 9]. This could be a result of the descriptive study designs used which aimed to gather further

information regarding the phenomenon, without specifying an expected outcome.

Sample

The articles described a heterogeneous composition of samples. The samples were composed of mental health nurses [1, 2, 3, 4, 6, 8 & 9], support workers [1, 2, 6, 8 & 9], occupational therapists [2, 4, 6, 7, 8 & 9], social workers [2, 4 & 8], a drama therapist [8], doctors and psychiatrists [4, 7, 8 & 9], a clinical coordinator [7] and direct care staff [5]. Article [3] did not clearly outline a full description of the sample composition. In all but one of the articles, participants were requested to have experienced shared formulations prior to the collection of data [8]. It was surprising that this article outlined that some participants had never experienced shared formulations and in spite of this, their perceptions of shared formulations were included in the findings [8]. The article did not differentiate the perceptions of those who had not experienced shared formulations from their findings, questioning the value of these results. Overall the samples were heterogeneous which is believed to provide rich data, as a range of perceptions from the broad sample was collected. This is likely to strengthen the external validity of the findings (Blankertz, 1998).

Sampling methods used in the studies was not stated in the majority of articles. In three articles, participants were reported to be selected on a voluntary basis [1, 2 & 6]. This opportunistic sampling method may lead to biases within the sample, as participants who volunteered to the studies may have a particular stake in the topic which may have influenced their reports, threatening the internal validity of the studies (Finger & Rand, 2003; Rosnow & Rosenthal, 2005). However, it is likely that this method of sampling was most convenient for the researchers, considering their work commitments and availability of team members.

Data collection

Interviews and self-report measures.

The studies used either semi-structured interviews or self-report measures to collect data. A total of five articles reported using semi-structured interviews [2, 4, 6, 8 & 9] and three articles used qualitative and quantitative self-report measures [1, 5 & 7]. None of the articles detailed either the interview schedules or the items used in the measures, but instead outlined overarching topics and limited information on the items. The vagueness of the interview schedules and measures make it difficult to assess the construct validity of the questions used to derive findings. This further introduces reliability issues as interested researchers may be unable to

replicate these studies (Spencer & Ritchie, 2012). The reliability and validity of the measures used was discussed in one of the three articles that outlined the use of qualitative and quantitative measures [1], questioning the validity of the measures in the rest of the articles.

Time span between experiencing shared formulation and data collection.

In all but one article [3] staff members' perceptions were either collected immediately following their experience of shared formulations or participants were requested to recall past experiences of shared formulations. With regards to immediate responses gathered from staff members, it was found that three studies undertook data collection between one to six hours following a formulation being shared [1, 5 & 7]. It is likely that the proximity of this event may have aided recall of the shared psychological formulations; however participants' reports may have been influenced by social desirability factors [1, 5 & 7]. A further limitation to these studies is that the short time spans do not capture the impact of shared formulations on staff members' clinical practice and it would have been beneficial to track the influence over time. Participants who were requested to recall past experiences of shared formulations [2, 4, 6, 8 & 9] may have found it difficult to accurately report on this due to the reliance on retrospective data. It would have been difficult to denote the particular influence of the shared formulations, as

there may have been other factors that may have led to these results. Validity issues are identified relating to the effects of the time span chosen by the researchers to gather data from participants.

Researchers' involvement.

The articles showed that the researchers' involvement in the studies could have impacted on the process of data collection, influencing the validity of the findings. The studies do not make it clear who was directly collecting the data and whether the clinical psychologist who was sharing the psychological formulation was also the researcher [1, 5 & 7]. It is assumed that if the researcher was part of the intervention then it is likely that participants may have responded in a favourable manner, which could have threatened the external validity of the findings (Finger & Rand, 2003; Matthews & Ross, 2010). In three articles it is reported that participants had a working relationship with the researcher collecting the data [2, 6 & 9]. These articles outlined the limitations and safeguards that were implemented in order to minimise bias. It is likely that participants may have reported their perceptions in a favourable manner in order to preserve their working relationships. A sum of five articles clearly identified the researchers as consultant, trainee or assistant clinical psychologists [2, 4, 5, 6, 7 & 9]. It is suggested in Luborsky et al's (1999) findings that it is likely that reported treatment

outcomes may be influenced by the researchers' allegiances. Researchers' allegiance could have led to researchers' expectancy bias which may have influenced the data collection and interpretation of the findings (Rosnow & Rosenthal, 2005). It is assumed that if the participants were aware of the professional status of the researcher and their allegiance to their practice, this could have influenced the reports they gave relating to the shared psychological formulations. Researchers' involvement in this research could have had a major impact on the validity of the findings.

Data analysis

This section will discuss the methods of data analysis used and researchers' epistemological stances. The articles outlined a range of qualitative and quantitative methods of analysis used in the studies. Articles that used qualitative methods of analysis reported using thematic analysis [4 & 6], collapsing themes [2, 7 & 9] and a grounded theory-based method of analysis [8]. One of the above articles used both thematic and content analysis with limited justification for this [9]. With regards to the quantitative measures, it was found that only one of two quantitative articles reported using t-tests to analyse the findings [1]. The analytical process was justified in two of the seven articles that outlined the analysis used [1 & 6]. The lack of detail relating to the data analysis and the process by which this was undertaken reduces the transparency of this

process, questioning the credibility in the findings (Spencer & Ritchie, 2012).

The majority of the articles did not outline the researchers' epistemological stances and the effect of this on the data analysis process. Amongst the nine articles, only one article outlined that the researcher had adopted a realist theoretical orientation [6]. Measures taken to minimise researchers' bias were outlined including the use of supervision, audit trails kept for transparency and checking of codes by supervisors [6]. The rest of the articles did not outline this, which presents difficulty in ascertaining the framework in which the findings were analysed.

Findings

Narrative synthesis was chosen for this review to synthesise the findings from the diverse studies presented in the articles. This method of synthesis has been implemented in other systematic literature reviews (Niemelä, Hakko & Räsänen, 2010; Rodgers et al. 2009). The guidance produced by the ESRC Methods Programme was used in this review as it provided clarity of the process of synthesising findings in a narrative manner (Popay et al, 2006). Amongst the articles, it was found that staff members' reports relating to the shared formulation overlapped with other aspects of the formulation, such as the meeting itself, as shown in Table 7. The following

section will primarily focus on presenting the findings relating to the impact of the shared formulation extracted from the articles and these will be weighted according to their quality.

Narrative synthesis.

Shared formulations were reported to increase the staff members' understanding of the client's problems [1, 3, 6, 8 & 9]. It should be noted that the five articles presented this perception mainly as a summary statement. This weakened the credibility of this finding as there was a lack of detail relating to this. It was found that the rest of the articles reported a similar impact resulting from the formulation meeting and approach [2, 4, 5, 7 & 9].

In total four articles outlined that staff members reported an emotional change following shared psychological formulations [1, 3, 4 & 8]. This was reported to be feelings of empathy and positivity towards the client. It was found that two articles reported that shared psychological formulations led to feeling positive about the client [1 & 3]. Following experiencing a shared psychological formulation, one article reported a "shift in attitude" whereby the client was no longer viewed as "just really annoying" but rather "an individual who had faced significant difficulties throughout life and who had made so much progress" (p. 6) [3]. The other article reported a significant decrease of staff members' feelings of negativity

towards a client, after completing Likert scales relating to a workshop attended where a formulation was shared [1]. This decrease was found to be statistically significant and a large effect size was derived from this result (ES^4 : 0.94) [1]. Both of these articles [1 & 3] presented findings that were retrieved immediately after the formulation was shared which may have influenced by social desirability effects, questioning the internal validity of the findings. As mentioned above, it was reported in two articles that shared formulations led staff members to empathise with the client [4 & 8]. These articles reported this with a summary statement without detailing how this impacted on the staff members' practice. This finding was also found in article [7] where it was reported to be an effect of the meeting itself.

In one article, staff members reported that they were able to tolerate their own difficult emotions following shared formulations [6]. A staff member reported that ““When you’re with somebody (...) its very difficult to keep a lid on it, we’re all human being. And that’s what [the psychologist] actually taught [him or her]; it was ok to feel like that” (p. 444) [6]. From this quotation the authors inferred that the shared formulation enabled the staff members to tolerate difficult emotions. The article does not consider other contributory factors that may have led to this result, including the

⁴ ES= effect size

relationship the staff member had with the psychologist. It would have been useful to further explore what the participant believed the psychologist had “taught” them and whether this was related to the formulation.

In two articles, staff members reported that shared formulations increased their confidence in supporting the client [1] and in decision making [4]. Article [1] reported that there was a significant increase in reported confidence in working with a client following presentation of the formulation. The increase was found to be statistically significant and a medium effect size was derived from this finding (ES: .58) [1]. It should be noted that the participants’ reports were susceptible to social desirability influences, as immediate responses following the formulation meeting were requested. This finding does not consider the effect of outliers and how these could have skewed the data, as group means were used to ascertain changes in perceptions. With regards to decision making, it was reported by a staff member that a psychological formulation consisted of a “rationale, theory and process” (p. 113) [4] and this credibility led to this boost in confidence in decision making. A limitation of this evidence is the lack of detail in illustrating how this influenced the professionals’ practice and in particular what benefits were obtained from this.

Amongst the nine articles, only one article reported that staff members indicated that shared formulations impacted on

their clinical practice [8]. This article outlined that twelve of its participants had stated this impact and the following quotation was presented in the article “[A formulation]... gives you a way of working that you might not have seen... gives direction. We were reminded of her sensitivity to rejection, so re-wrote some care plans in light of this.” (p. 342) [8]. A shortcoming of this article is that it does not outline how the participants operationalised the term ‘psychological formulation’. It remains unclear if participants understood the phenomenon of the formulation as the researchers did, and therefore this finding may have questionable validity. This finding was also found in articles that have reported similar benefits relating to the meeting itself [2, 5, 6 & 9].

It was outlined in one article that staff members reported that shared psychological formulations provided a range of new skills [4]. The following quotation was outlined in the article: “It kind of gives you more in your tool box, more things to draw on... and think about things in different ways” (p. 113) [4]. The credibility of this finding is questioned as it is unclear how the shared formulations led to this impact and there appears to be minimal information relating to the “tools” adopted. In relation to this, it was outlined in the same article that staff members reported generation of “new thinking” following a shared formulation [4]. This “new thinking” was summarised with limited detail on how this was operationalised

by the participants, questioning the credibility of this finding. As presented in Table 7, this finding was also reported to relate to the formulation meeting itself [2 & 6].

Staff members reported improved team working following a shared psychological formulation [4 & 8]. It was reported that the shared formulation was helpful as team members were able to recognise “if somebody is drawn into a negative transference and they are feeling angry with the patient” (p. 133) [4]. It is not outlined how this recognition benefited the team’s dynamics. This report was also identified in articles reporting the impact of formulation meetings rather than the formulation itself [2 & 6].

There was an article that outlined associations relating to the impact of shared formulations and staff perceptions of a client’s behaviour [5]. The article concluded that staff members’ perceptions of the severity of challenging behaviour decreased following understanding a shared formulation [5]. Participants had attended a workshop that included a presentation of a formulation, however the authors did not consider the confounding variables within these meetings that could have led to these findings. The article also reported that following the shared formulation the recording of the frequency of the client’s behaviour significantly decreased in the six months post-intervention [5]. The article proposes an association between the formulation and the frequency of the

challenging behaviour. It is not considered that confounding factors may have led to this, such as a gradual decrease of behaviour because of other variables within the setting.

Amongst the articles, only one disadvantage was outlined relating to shared formulations [8]. It was reported that shared formulations could “give too much emphasis to excuses for patients’ behaviour’ or conclude ‘wrong perspectives through reading too deeply” (p. 342) [8]. It should be noted that in this study some participants had not experienced psychological formulations, therefore it is unclear whether these were their views, as these were not distinguished from the rest of the sample. A different article outlined that ‘psychological factors’ included in care plans led to unhelpful results [9]. It is unclear whether psychological factors incorporated formulations, raising issues relating to the internal validity of this finding. In both of these articles staff members’ reports relied on retrospective information and therefore it may have been difficult to explore the influences of the shared psychological formulation due to possible contributory factors. It is possible that a lack of negative results could be a result of the opportunistic sampling methods, which could have influenced the validity of the findings.

Discussion

Limited evidence was reported regarding the impact of shared psychological formulations. A common finding across five of the reviewed articles was reports that shared formulations increased staff members' understanding of client's problems. However, there was a lack of detail regarding this benefit, questioning the credibility of the finding. As outlined in the review, most of the evidence found in the articles reported the impact of other aspects of the shared formulation such as the meeting rather than the shared formulation itself (Table 7). It was acknowledged that this could have been a result of the varied aims of the studies. Amongst the articles only one disadvantage was reported regarding the direct impact of shared formulations; however this evidence may have questionable validity. Limited negative reports could be a result of the biases presented by the opportunistic sampling methods adopted by the researchers.

The narrative synthesis framework assisted in organising and summarising the findings, by identifying similarities and differences within articles. The reviewer constructed Table 7 in order to present these findings indicating how some findings were related to other aspects of the formulation such as the meeting itself. The presentation of the evidence relating to the findings increased the credibility of the discussion outlined in the review.

As outlined in the review there was a lack of consistency relating to the operationalisation of psychological formulations amongst the researchers and compared to the participants. The inconsistency relating to the researchers could have been a reflection of the lack of agreement within the clinical psychology field regarding the definition of a psychological formulation (DCP, 2011). A lack of an agreed operationalisation of phenomenon between the researchers and participants raised questions, as it was unclear that the same phenomenon was being investigated, questioning the validity of the findings. It is disputable if these studies could be compared due to limited evidence regarding the operationalisation of the phenomenon being investigated.

The data collection methods and the study designs presented difficulties in differentiating the impact of psychological formulations for non-psychology staff members. Causal inferences of shared psychological formulations were difficult to ascertain as the studies did not control for any confounding factors that could have had a moderating influence on the shared formulation, such as the team members' relationships (Finger & Rand, 2003; Rosnow & Rosenthal, 2005). These issues resulted in difficulties ascertaining the credibility and the validity of the findings relating to the impact of shared psychological formulations.

The review was conducted by the first author and it is acknowledged that there may be elements of bias because of this. The reviewer solely adapted the quality appraisal and undertook the review without this process being assessed by other reviewers. The use of triangulation with multiple reviewers could have reduced the bias in this review. The results could have been sent to the authors to ascertain validity of results, particularly for articles with limited information.

Recommendations

The review retrieved inadequate research regarding the impact of psychological formulations shared amongst non-psychology staff members. The evidence that was found relating to the impact of shared psychological formulation was limited. In relation to this, conclusive inferences could not be made regarding the impact of shared formulation amongst non-psychology staff members. Based on the findings from this review, clinical psychologists are advised to take the findings listed in clinical psychology professional documents tentatively, as some of these cited articles appear to have significant methodological flaws. Furthermore clinical psychologists are requested to consider undertaking research in this area, as this review highlights a need for future research.

It would be beneficial for researchers to consider the following aspects which could address the flaws identified in

the reviewed studies. It should be noted that these are some ideas for future research and therefore these aspects are not intended to be taken in a prescriptive manner as there would be other ways in which the issues detailed in this review could be tackled.

- The research requires a clear operationalisation of the term ‘psychological formulation’. The researcher should outline the participants understanding of this phenomenon. It would be beneficial to understand if shared psychological formulations meet the expectations of the researchers and the participants.
- Clinical psychologists could consider undertaking cohort studies whereby staff members’ perceptions of existing clients could be assessed before and after the presentation of a formulation. In addition to this, participants could be requested for their consent for data collection to take place at multiple baselines in order to understand the impact of the shared formulation over time. A comparison between staff members who have and those who have not experienced shared psychological formulations could assist in understanding the impact of this practice. A waiting list control or attention placebo group could be recruited in order to assist in understanding the impact of shared psychological formulations.

- With regards to data collection, clinical psychologists could consider employing external data collectors in order to minimise biases that could be presented with their involvement. It would be beneficial for items in the data collection measures to be detailed in articles to increase transparency of the data collection process.
- A clear outline of the data analysis would be useful in order to increase transparency of the process.

Researchers could outline their epistemological stance so readers could understand how the findings may have been interpreted. In order to increase transparency and credibility of findings, it would be beneficial for the researcher to present to data linked to the findings.

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tml](http://www.psychosocial.com/IJPR_12/Using_Psychological_Formulation_Hewitt.html)

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Note. References marked with an asterisk indicate articles included in this review.

Table 1

Keywords and search terms used when searching Peer-reviewed Journals

Medline (1946 to 19/6/2013)

1. (psychological adj10 formulat*).mp. (145)
2. "case conceptuali?ation".mp. (54)
3. (shar\$ adj10 formulat*).mp. (162)
4. (psycholog\$ adj10 formulat*).mp. (206)
5. "case formulat?".mp. (1)
6. 1 or 2 or 3 or 4 (422)
7. team\$.mp. (122177)
8. (multi adj3 disciplinary).mp. (2911)
9. meeting.mp. (62981)
10. exp "Attitude of Health Personnel"/ (90880)
11. exp Medical Staff, Hospital/ or Medical Staff/ (22040)
12. exp Hospitals, Psychiatric/ (22118)
13. "clinical practice".mp. (90836)
14. "reflective practice".mp (576)
15. consultation.mp. or "Referral and Consultation"/ (82048)
16. 5 or [6 and (7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15)] (50)

PsycINFO (1806 to 19/6/13)

1. (psychological adj10 formulat*).mp. (858)
2. "case conceptuali?ation".mp. (922)
3. (shar\$ adj10 formulat*).mp. (183)
4. (psycholog\$ adj10 formulat*).mp.(1839)
5. "case formulat?".mp. (0)
6. 1 or 2 or 3 or 4 (2907)
7. exp Teams/ or exp Work Teams/ (10114)
8. (multi adj3 disciplinary).mp. (1279)
9. meeting.mp. (26924)
10. exp Health Personnel Attitudes/ or exp "Mental Illness (Attitudes Toward)"/ or exp "Work (Attitudes Toward)"/ or exp Psychologist Attitudes/ or exp Employee Attitudes/ or exp Therapist Attitudes/ (48755)
11. exp Health Care Services/ or exp Psychiatric Hospital Staff/ or exp Psychiatric Patients/ or exp Mental Health Services/ (99504)
12. exp Psychiatric Hospitals/ (6642)
13. exp Clinical Practice/ (10087)
14. reflective practice.mp. (1089)
15. exp Professional Consultation/ (8524)

16. 6 and (7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15) (210)

EMBASE (1980 to 19/6/13)

1. (psychological adj10 formulat*).mp. (244)
2. "case conceptuali?ation".mp. (145)
3. (shar\$ adj10 formulat*).mp. (246)
4. (psycholog\$ adj10 formulat*).mp. (358)
5. "case formulat?".mp. (1)
6. 1 or 2 or 3 or 4 (746)
7. team\$.mp. (125107)
8. (multi adj3 disciplinary).mp. (5517)
9. meeting.mp. (88098)
10. exp attitude/ or attitude to health/ or health personnel attitude/ or patient attitude/ or attitude to mental illness/ or employee attitude/ or attitude to change/ (227259)
11. exp medical staff/ or staff/ (30965)
12. exp hospital care/ or hospital/ or mental hospital/ or hospital service/ (257015)
13. clinical practice/ (155817)
14. reflective practice.mp. (840)
15. consultation/ (51194)

16. 5 or [6 and (7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15)] (119)

Applied Social Sciences Index and Abstracts (ASSIA) last search 20/7/13

1. case conceptualization (276)
2. psycholog* formulat* (824)
3. shar* formulat* (171)
4. case formulat* (619)
5. 1 or 2 or 3 or 4 (1670)
6. team (11935)
7. su.exact("clinical practice") (1421)
8. meeting (6505)
9. staff (18107)
10. multidisciplinary (3025)
11. attitudes (31381)
12. su.exact("reflective practice") (361)
13. consultation (4949)
14. 5 and (6 or 7 or 8 or 9 or 10 or 11 or 12 or 13) (225)

Note. (X)= Number of articles obtained

Table 2*Search terms used in Grey Literature Search (completed on the 21/7/13)*

<u>Database</u>	<u>Keywords and search terms</u>
EthOs (182)	<p>psychological formulation (144)</p> <p>psychological formulation and consultation (5)</p> <p>psychological formulation and reflective practice (11)</p> <p>psychological formulation and team (9)</p> <p>psychological formulation and staff (13)</p>
Copac (75)	<p>title words: psychological formulation (10)</p> <p>title words: psychological formulation and consultation (0)</p> <p>keyword: psychological formulation and reflective practice (12)</p> <p>keyword : psychological formulation and team (53)</p>
PsycArticles Full	psycholog* formulat* and team (14)
Text (53)	<p>psycholog* formulat* and staff (21)</p> <p>psycholog* formulat* and reflective practice (1)</p> <p>psycholog* formulat* and consultation (17)</p>
Scopus (31)	<p>case conceptuali?ation and team (4)</p> <p>case conceptuali?ation and reflective practice (3)</p> <p>case conceptuali?ation and consult* (5)</p> <p>case conceptuali?ation and staff (5)</p> <p>psycholog* formulat* and team (6)</p> <p>psycholog* formulat* and reflective practice (0)</p>

	psycholog* formulat* and consult* (2)
	psycholog* formulat* and staff (6)
Google scholar (50)	psychological formulation and team (17)
	psychological formulation and consultation (15)
	psychological formulation and reflective practice (4)
	psychological formulation and staff (14)
Opengrey (46)	reflective practice (23)
	psychological formulation (1)
	case conceptualisation (0)
	case conceptualization (2)
	consultation and psychology (20)
Index to theses	psychology* formulat* (7)
(229)	reflective practice (184)
	consultation and psychology (38)
PsychSource (70)	psychological formulation and team (9)
	psychological formulation and staff (11)
	psychological formulation and reflective practice (27)
	psychological formulation and consultation (7)
	case conceptualisation and team (1)
	case conceptualisation and staff (3)
	case conceptualisation and reflective practice (11)
	case conceptualisation and consultation (1)

Note. (X)= Number of articles obtained

Table 3*Hand searched references*

<u>Type of resource</u>	<u>Title of resource</u>
PD	Division of Clinical Psychology (2010). <i>The core purpose and philosophy of the profession</i> . Leicester: British Psychological Society.
PD	Division of Clinical Psychology (2011). <i>Good practice guidelines on the use of psychological formulation</i> . Leicester: British Psychological Society.
PD	Skinner, P., & Toogood, R. (2010). <i>Clinical psychology leadership development framework</i> . Leicester: British Psychological Society.
PD	British Psychological Society (2001). <i>Working in teams</i> . Leicester: British Psychological Society.
PD	Onyett, S. (2007). <i>New ways of working for applied psychologists in health and social care: Working psychologically in teams</i> . Leicester: British Psychological Society.
PD	British Psychological Society (2011). <i>Guidelines for clinical psychology services</i> . Leicester: British Psychological Society.
BC	Whomsley, S. (2010). Team case formulation. In C. Cupitt (Eds.), <i>Reaching out: The psychology of assertive outreach</i> (pp. 95-118). East Sussex: Routledge.

- BC Johnstone, L. (2013). Using formulation in teams. In L. Johnstone, & R. Dallos (2nd ed.), *Formulation in psychology and psychotherapy: Making sense of peoples problems* (pp. 216-242). East Sussex, UK: Routledge.
- C Johnstone, L. (2013, May). *Using formulations in teams*. Organised by the Division of Clinical Psychology & BPS learning centre

Note. PD= professional documents; BC= book chapters; C= conference

Table 4

Relevant articles not accessible

Grey literature search

^a Thomas, S. (2008). *An evaluation of the use of formulation in core assessments produced by CMHT staff*. (Unpublished service evaluation). Bristol Clinical Psychology Doctorate, UK.

Hand searched articles

^a Gail, F. (2011). *A grounded theory study of psychological formulation driven consultation for complex cases*. (Unpublished doctoral theses). University of Liverpool Doctorate in Clinical Psychology, UK.

^b Hollingworth, P. & Johnstone, L. (2012) Staff perceptions of the benefits of team formulation in secondary care adult mental health teams. *Clinical Psychology Forum* (in press.)

^b Hollingworth, P. & Johnstone, L. (2013). Team formulations: what are staff views? *Clinical Psychology Forum* (in press.)

^a Davies, L. (2010) *Consultation to a local residential children's home: the process of service development, implementation and evaluation, illustrated with a case study*. (Unpublished report of clinical activity). Cardiff Doctorate in Clinical Psychology, UK.

^b Down, R. (2010) *CAMHS Residential Care Consultation Service: 4 month review to April 2010*. Internal Trust report, Hywel Dda Health Board, Wales.

Note. ^a= articles not accessed due to university restrictions on access of material. ^b= articles that could not be found in the databases.

Table 5*General characteristics of the nine articles*

<u>Authors</u>	<u>Study aims</u>	<u>Sample size and composition</u>	<u>Data collection</u>	<u>Data analysis</u>	<u>Key findings</u>
[1] Berry, Barrowclough & Wearden (2009)	To explore the effects of the formulation process on staff appraisals.	30 staff from three psychiatric rehabilitation units. 50% were female, Mean age was 39.87 (SD=8.01) years, 90% were White British; Mean number of years of experience in mental	Pre- and post- measures completed: the Brief Illness Perception Questionnaire and the Illness Perception Questionnaire for Schizophrenia	Repeated measures t-tests	<ul style="list-style-type: none"> Staff had more helpful attitudes towards working with service users (SU) after the formulations were shared. Following shared formulations, staff reported better understanding of SU problems, rated their feelings towards SU as

health 9.14 years
(SD=8.01), 53%
were registered
mental health nurses
& 46.7% were
mental health
support workers.

being less negative and
reported greater
confidence in working
with SU.

- Following shared formulations, staff members reported that they were more likely to perceive that SU had greater control over problems.
- Following shared formulations, staff members rated SU as putting more effort into

					getting well, being less likely to have caused their problems and being less likely to blame for their problems.
[2] Craven-Staines, Dexter-Smith & Li (2010)	Audit: to explore staff perceptions of the formulation meetings within their localities.	20 staff members. 14 were qualified staff members and 6 were unqualified. A variety of professional backgrounds included staff nurses, occupational	Semi-structured interviews facilitated by a volunteer psychologist	Not specified however themes in data were gathered.	<ul style="list-style-type: none"> • Formulation meetings increased understanding of client's presenting problems. • Formulation meetings supported development of individualised care plans. • Following formulation meetings, staff reported thinking differently with

		therapists, social workers and health care assistants.			regards to clinical work.
[3] Hewitt (2008)	Case study: report detailing intervention implemented with a client.	5 staff members attended formulation meeting including client's keyworker and nurse.	Not specified	Not specified	<ul style="list-style-type: none"> The collaborative formulation sessions were helpful and allowed staff members to develop a positive and detailed picture of the client's life.
[4] Hood, Johnstone & Christofides (2013)	In-depth exploration of staff experiences of psychological formulations.	9 qualified and unqualified members of the multidisciplinary team	Semi-structured interviews	Thematic analysis	<ul style="list-style-type: none"> Staff members reported that the formulation approach explained client's presenting difficulties better than medical diagnosis.

5 community mental
health nurses, 1
mental health
support worker, 1
psychiatrist, 2 social
workers

- Staff felt empowered during the formulating process.
- Staff reported feeling more confident in making decisions after the shared formulation.
- Formulations helped with team dynamics.
- Formulations assisted in a whole new way of thinking and working.
- Formulations helped staff to empathise with the person and engage

					positively with the client.
[5] Ingham (2011)	To pilot novel collaborative formulation workshops with direct care staff.	7 direct care staff members	Pre and Post intervention measures: Observational behavioural recording over 2 months before the workshop and 6 months after intervention. Carer baseline questionnaire to assess staff perceptions of	Not specified. However, mean scores of observed behaviour over time and themes from self-report measures	<ul style="list-style-type: none"> • Direct care staff team's perceptions of the severity of challenging behaviour decreased after attending the workshops. • Carers reported workshops helped in understanding client's behaviour and found that recommendations could be made based on this understanding.

severity of client's were
presenting challenging reported
behaviour.

Post intervention
measure:

Workshop evaluation
questionnaires (closed
and open questions)

[6] Murphy, Osborne & Smith (2013)	To explore the perceptions of psychological consultation in inpatient staff	10 participants recruited from a pool of approximately 30. 5 qualified nurses, 4	Semi-structured interviews	Thematic analysis	<ul style="list-style-type: none"> Psychological consultation enabled to better view the client in the context of their history. It helped staff develop more
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working with older
adult inpatient
services.

nursing assistants
and 1 occupational
therapy technical
assistant

Study aimed to
explore the ways in
which formulation
consultation
impacted on staff's
daily practice, and
the mechanisms of
change involved.

Participants had
worked on the units
for duration of 8
months to 12 years.

positive, supporting
relationships with clients.

- Staff reported a greater understanding of client's presenting problems because of the shared formulation.
- Psychological formulations helped to tolerate difficult emotions.
- Formulation meetings enabled a space for staff members to share information which resulted in better team working.

					<ul style="list-style-type: none"> Formulations meetings helped develop person-centred care plans.
[7] Robson & Quayle (2009)	Description of a model of communicating shared formulations	<p>7 multidisciplinary team members from one ward</p> <p>2 psychiatry SHOs, 1 consultant psychiatrist, 1 occupational therapist, 1 senior occupational therapist/care manager, 1 clinical</p>	<p>Evaluation forms which consisted of four open- ended questions.</p>	<p>Not specified, however themes from data were said to have been gathered.</p>	<ul style="list-style-type: none"> Formulation meeting helped decrease feelings of frustrations, facilitated a more holistic view, improved empathy and helped to provide additional ideas about interventions with the client.

		coordinator and 1 staff nurse.			
[8] Summers (2006)	To understand the benefits and limitations of using psychological formulations for patients with severe mental illness.	25 participants from one ward. 9 nurses, 11 support workers, 2 doctors, 1 occupational therapist, 1 social worker, 1 drama therapist 10 out of 12 of the professionally	Interviews facilitated by author.	Grounded- theory based methodolo gy	<ul style="list-style-type: none"> • Most participants said they could see few or no drawbacks of shared formulations. • Some of the drawbacks included formulations not being productive, seen as speculative suggestions that could lead to wrong perceptions of clients. Others thought the past was over-emphasised and

trained staff had read and attended formulation meetings, amongst the 11 support workers and 2 students only 6 had attended formulation meetings and 1 had read a written formulation.

could be used as an “excuse for current behaviour”.

- Formulations led to positive influence on care planning, better staff-patient relationships and improved team working.
- Formulation meeting brought information together, leaving staff feeling valued and part of the team.

[9] Wainwright & Bergin (2010)	Service evaluation: exploring staff views	5 participants:	Semi-structured interviews	Content and	<ul style="list-style-type: none"> • Shared formulations and the meetings helped
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of psychological formulation work in an older people inpatient setting.	2 registered nurses, 1 health support worker, 1 occupational therapist, and 1 staff grade doctor. All participants worked on the same ward.	thematic analysis	develop a shared understanding of the service user's presenting problems. • Formulation meeting led to a positive impact on the care of service users. • Formulation meetings led to a positive impact on care plans. • Psychological factors used in the care plans led to unhelpful results.
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Note. [X] = article reference numbers

Table 6*Methodological quality*

<u>Appraisal Question</u>	<u>Criterion grades</u>								
	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]
How credible are the findings?	3	1	0	3	3	3	0	1	3
How has knowledge understanding been extended by the research?	3	0	0	3	2	3	1	0	2
How well does the evaluation address its original aims and purpose?	3	2	0	2	3	3	1	2	0
Scope for drawing wider inference- how well is this explained?	3	0	0	3	2	3	0	0	0
How clear is the basis of evaluative approach?	0	0	0	2	1	2	1	0	0
How defensible is the research design?	1	1	0	3	2	3	1	0	3
How well defended is the sample design/ target selection of cases/ documents?	1	2	1	3	1	3	0	0	1
Sample composition/ case inclusion- how well is the eventual coverage described?	1	1	2	3	0	2	0	1	1
*Representativeness of intervention cohort, comparability of cohorts with controls									
How well was the data collection carried out?	1*	3	3	3	1*	3	0	1	3
*Rationale given for measures used; detailed information regarding the items used, reliability									

and validity of these stated, time span between measures stated and acknowledged.

How well has the approach to and formulation of the analysis been conveyed?	1*	0	0	2	0*	3	0	0	1
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* Rationale for choice of data analysis used, adequacy of follow up process of cohort, was follow up period of time enough for outcomes to occur, extent to which samples were compared.

Contexts of data sources- how well are they retained and portrayed?	3	3	3	0	3	0	0	2	1
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How well has the diversity of perspectives and content been explored?	2	2	0	2	1	2	0	0	1
---	---	---	---	---	---	---	---	---	---

How well has detail, depth and complexity (i.e. richness) of the data been conveyed?	3	2	0	1	3	3	0	0	0
--	---	---	---	---	---	---	---	---	---

How clear are the links between data, interpretation (results*) and conclusions- i.e. how well can the route to any conclusions be seen?	2*	0	0	2	2*	3	0	0	2
--	----	---	---	---	----	---	---	---	---

How clear and coherent is the reporting?	3	2	2	3	3	3	1	1	3
--	---	---	---	---	---	---	---	---	---

How clear are the assumptions/ theoretical perspectives/ values that have shaped the form and output of the evaluation?	1	0	0	0	0	3	1	0	1
---	---	---	---	---	---	---	---	---	---

What evidence is there of attention to ethical issues?	0	3	1	1	0	3	1	0	0
--	---	---	---	---	---	---	---	---	---

How adequately has the research process been documented?	3	2	0	3	2	3	1	0	2
--	---	---	---	---	---	---	---	---	---

Overall grade	2	1	1	2	2	3	0	1	1
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Note. [X] = article reference numbers. Criterion grades given to each article: 3- when no or few flaws were found, 2- some flaws, 1- significant flaws, 0- when judged to be untrustworthy. * Appraisal questions derived from the Newcastle-Ottawa Scale included in this adapted framework.

Table 7*Staff members' reports and aspects of formulation related to these reports*

<u>Staff members' reports</u>	<u>Aspects of formulation</u>								
	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]
Increased confidence in supporting client	SF								
Feeling positive about client	SF		SF						
Increased understanding of client's problems	SF	FM	SF	FA	FM	SF	FM	SF	FM/
									SF
Assists in developing care plans and provides recommendations for future work		FM			FM	FM		SF	FM
Better quality of care		FM				FM			FM
Holistic view of client		FM					FM		
Generation of new thinking		FM		SF		FM			

Improved team working	FM	SF	FM	SF
Helped recognise professional skills	FM			
Provides space to reflect on client's presenting problem		SF		FM
Helps to empathise with client		SF	FM	SF
Provides new skills		SF		
Increased confidence in decision making		SF		
Decreases client's challenging behaviour and staff's perceptions of the severity of client's behaviour		SF	FM	
Enables staff to tolerate difficult emotions			SF	
Staff feel more or less valued			FM	FM
Negative effects for clients due to "wrong" or "overemphasised" factors in formulation				SF PF

Note. [X] = article reference numbers. SF= shared formulations; FM= formulation meetings; FA= formulation approach; PF= psychological factors.

Appendix A

Critical appraisal tool

FRAMEWORK FOR ASSESSING QUALITATIVE EVALUATIONS³

Study being appraised:

	a) Appraisal questions	b) Quality indicators (possible features for consideration)	c) Notes on study being appraised
1 FINDINGS	How credible are the findings?	Findings/conclusions are supported by data/study evidence (<i>i.e. the reader can see how the researcher arrived at his/her conclusions; the 'building blocks' of analysis and interpretation are evident</i>) Findings/conclusions 'make sense'/have a coherent logic Findings/conclusions are resonant with other knowledge and experience (<i>this might include peer or member review</i>) Use of corroborating evidence to support or refine findings (<i>i.e. other data sources have been used to examine phenomena; other research evidence has been evaluated: see also Q14</i>)	
2 FINDINGS	How has knowledge/ understanding been extended by the research?	Literature review (where appropriate) summarising knowledge to date/key issues raised by previous research Aims and design of study set in the context of existing knowledge/ understanding; identifies new areas for investigation (<i>for example, in relation to policy/practice/substantive theory</i>) Credible/clear discussion of how findings have contributed to knowledge and understanding (<i>e.g. of the policy, programme or theory being reviewed</i>); might be applied to new policy developments, practice or theory Findings presented or conceptualised in a way that offers new insights/alternative ways of thinking Discussion of limitations of evidence and what remains unknown/unclear or what further information/research is needed	

³ For those wishing to read further about qualitative and evaluative research methods a short list of useful references can be found at the end.



	a) Appraisal questions	b) Quality indicators (possible features for consideration)	c) Notes on study being appraised
3 FINDINGS	How well does the evaluation address its original aims and purpose?	<p>Clear statement of study aims and objectives; reasons for any changes in objectives</p> <p>Findings clearly linked to the purposes of the study – and to the initiative or policy being studied</p> <p>Summary or conclusions directed towards aims of study</p> <p>Discussion of limitations of study in meeting aims (<i>e.g. are there limitations because of restricted access to study settings or participants, gaps in the sample coverage, missed or unresolved areas of questioning, incomplete analysis, time constraints?</i>)</p>	
4 FINDINGS	Scope for drawing wider inference – how well is this explained?	<p>Discussion of what can be generalised to wider population from which sample is drawn/case selection has been made</p> <p>Detailed description of the contexts in which the study was conducted to allow applicability to other settings/contextual generalities to be assessed</p> <p>Discussion of how hypotheses/propositions/findings may relate to wider theory; consideration of rival explanations</p> <p>Evidence supplied to support claims for wider inference (<i>either from study or from corroborating sources</i>)</p> <p>Discussion of limitations on drawing wider inference (<i>e.g. re-examination of sample and any missing constituencies; analysis of restrictions of study settings for drawing wider inference</i>)</p>	
5 FINDINGS	How clear is the basis of evaluative appraisal?	<p>Discussion of how assessments of effectiveness/evaluative judgements have been reached (<i>i.e. whose judgements are they and on what basis have they been reached?</i>)</p> <p>Description of any formalised appraisal criteria used, when generated and how and by whom they have been applied</p> <p>Discussion of the nature and source of any divergence in evaluative appraisals</p> <p>Discussion of any unintended consequences of intervention, their impact and why they arose</p>	



	a) Appraisal questions	b) Quality indicators (possible features for consideration)	c) Notes on study being appraised
6 DESIGN	How defensible is the research design?	<p>Discussion of how overall research strategy was designed to meet aims of study</p> <p>Discussion of rationale for study design</p> <p>Convincing argument for different features of research design (<i>e.g. reasons given for different components or stages of research; purpose of particular methods or data sources, multiple methods, time frames etc.</i>)</p> <p>Use of different features of design/data sources evident in findings presented</p> <p>Discussion of limitations of research design and their implications for the study evidence</p>	
7 SAMPLE	How well defended is the sample design/target selection of cases/documents?	<p>Description of study locations/areas and how and why chosen</p> <p>Description of population of interest and how sample selection relates to it (<i>e.g. typical, extreme case, diverse constituencies etc.</i>)</p> <p>Rationale for basis of selection of target sample/settings/documents (<i>e.g. characteristics/features of target sample/settings/documents, basis for inclusions and exclusions, discussion of sample size/number of cases/setting selected etc.</i>)</p> <p>Discussion of how sample/selections allowed required comparisons to be made</p>	
8 SAMPLE	Sample composition/case inclusion – how well is the eventual coverage described?	<p>Detailed profile of achieved sample/case coverage</p> <p>Maximising inclusion (<i>e.g. language matching or translation; specialised recruitment; organised transport for group attendance</i>)</p> <p>Discussion of any missing coverage in achieved samples/cases and implications for study evidence (<i>e.g. through comparison of target and achieved samples, comparison with population etc.</i>)</p> <p>Documentation of reasons for non-participation among sample approached/non-inclusion of selected cases/documents</p> <p>Discussion of access and methods of approach and how these might have affected participation/coverage</p>	



	a) Appraisal questions	b) Quality indicators (possible features for consideration)	c) Notes on study being appraised
9	How well was the data collection carried out?	<p>Discussion of:</p> <ul style="list-style-type: none"> • who conducted data collection • procedures/documents used for collection/recording • checks on origin/status/authorship of documents <p>Audio or video recording of interviews/discussions/conversations (if not recorded, were justifiable reasons given?)</p> <p>Description of conventions for taking fieldnotes (e.g. to identify what form of observations were required/to distinguish description from researcher commentary/analysis)</p> <p>Discussion of how fieldwork methods or settings may have influenced data collected</p> <p>Demonstration, through portrayal and use of data, that depth, detail and richness were achieved in collection</p>	
10	How well has the approach to, and formulation of, the analysis been conveyed?	<p>Description of form of original data (e.g. use of verbatim transcripts, observation or interview notes, documents, etc.)</p> <p>Clear rationale for choice of data management method/tool/package</p> <p>Evidence of how <u>descriptive</u> analytic categories, classes, labels etc. have been generated and used (i.e. either through explicit discussion or portrayal in the commentary)</p> <p>Discussion, with examples, of how any <u>constructed</u> analytic concepts/typologies etc. have been devised and applied</p>	
11	Contexts of data sources – how well are they retained and portrayed?	<p>Description of background or historical developments and social/organisational characteristics of study sites or settings</p> <p>Participants' perspectives/observations placed in personal context (e.g. use of case studies/vignettes/individual profiles, textual extracts annotated with details of contributors)</p> <p>Explanation of origins/history of written documents</p> <p>Use of data management methods that preserve context (i.e. facilitate within case description and analysis)</p>	



	a) Appraisal questions	b) Quality indicators (possible features for consideration)	c) Notes on study being appraised
12	How well has diversity of perspective and content been explored?	<p>Discussion of contribution of sample design/ case selection in generating diversity</p> <p>Description and illumination of diversity/multiple perspectives/alternative positions in the evidence displayed</p> <p>Evidence of attention to negative cases, outliers or exceptions</p> <p>Typologies/models of variation derived and discussed</p> <p>Examination of origins/influences on opposing or differing positions</p> <p>Identification of patterns of association/linkages with divergent positions/groups</p>	
13	How well has detail, depth and complexity (i.e. richness) of the data been conveyed?	<p>Use and exploration of contributors' terms, concepts and meanings</p> <p>Unpacking and portrayal of nuance/subtlety/intricacy within data</p> <p>Discussion of explicit and implicit explanations</p> <p>Detection of underlying factors/influences</p> <p>Identification and discussion of patterns of association/conceptual linkages within data</p> <p>Presentation of illuminating textual extracts/observations</p>	
14	How clear are the links between data, interpretation and conclusions – i.e. how well can the route to any conclusions be seen?	<p>Clear conceptual links between analytic commentary and presentations of original data (<i>i.e. commentary and cited data relate; there is an analytic context to cited data, not simply repeated description</i>)</p> <p>Discussion of how/why particular interpretation/significance is assigned to specific aspects of data – with illustrative extracts of original data</p> <p>Discussion of how explanations/ theories/conclusions were derived – and how they relate to interpretations and content of original data (<i>i.e. how warranted</i>); whether alternative explanations explored</p> <p>Display of negative cases and how they lie outside main proposition/theory/ hypothesis etc.; or how proposition etc. revised to include them</p>	



	a) Appraisal questions	b) Quality indicators (possible features for consideration)	c) Notes on study being appraised
15 REPORTING	How clear and coherent is the reporting?	<p>Demonstrates link to aims of study/research questions</p> <p>Provides a narrative/story or clearly constructed thematic account</p> <p>Has structure and signposting that usefully guide reader through the commentary</p> <p>Provides accessible information for intended target audience(s)</p> <p>Key messages highlighted or summarised</p>	
16 REFLEXIVITY & NEUTRALITY	How clear are the assumptions/theoretical perspectives/values that have shaped the form and output of the evaluation?	<p>Discussion/evidence of the main assumptions/hypotheses/theoretical ideas on which the evaluation was based and how these affected the form, coverage or output of the evaluation (<i>the assumption here is that no research is undertaken without some underlying assumptions or theoretical ideas</i>)</p> <p>Discussion/evidence of the ideological perspectives/values/philosophies of research team and their impact on the methodological or substantive content of the evaluation (<i>again, may not be explicitly stated</i>)</p> <p>Evidence of openness to new/alternative ways of viewing subject/theories/assumptions (<i>e.g. discussion of learning/concepts/ constructions that have emerged from the data; refinement/ restatement of hypotheses/theories in light of emergent findings; evidence that alternative claims have been examined</i>)</p> <p>Discussion of how error or bias may have arisen in design/data collection/analysis and how addressed, if at all</p> <p>Reflections on the impact of the researcher on the research process</p>	



	a) Appraisal questions	b) Quality indicators (possible features for consideration)	c) Notes on study being appraised
17 ETHICS	What evidence is there of attention to ethical issues?	Evidence of thoughtfulness/sensitivity about research contexts and participants Documentation of how research was presented in study settings/to participants <i>(including, where relevant, any possible consequences of taking part)</i> Documentation of consent procedures and information provided to participants Discussion of confidentiality of data and procedures for protecting Discussion of how anonymity of participants/sources was protected Discussion of any measures to offer information/advice/services etc. at end of study <i>(i.e. where participation exposed the need for these)</i> Discussion of potential harm or difficulty through participation, and how avoided	
18 AUDITABILITY	How adequately has the research process been documented?	Discussion of strengths and weaknesses of data sources and methods Documentation of changes made to design and reasons; implications for study coverage Documentation and reasons for changes in sample coverage/data collection/analytic approach; implications Reproduction of main study documents <i>(e.g. letters of approach, topic guides, observation templates, data management frameworks etc.)</i>	

Note. The above critical appraisal tool was retrieved from Spencer, Ritchie, Lewis, and Dillon, 2003.

JOURNAL ARTICLE

Outcomes of team formulation: Community mental health professionals' perceptions

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Objectives

Community Mental Health Teams' (CMHTs') perceptions of the outcomes/ products of team formulation are drawn from a wider study of team formulation. This paper addresses research questions: (1) what are considered helpful or unhelpful aspects of the outcomes of team formulation and (2) what factors may influence these outcomes.

Design

A qualitative design was used utilising a contextualist, critical-realist paradigm.

Methods

12 CMHT members who attended team formulation were recruited from three sites within the British National Health Service. In each site, an individual interview with a clinical psychologist and a focus group with three professionals were conducted. An inductive thematic analysis was used.

Results

Across all transcripts participants reported that ideas derived from team formulation, integrated into care plans (CPs) were integral and that these CPs were valued outcomes/ products of team formulation. Participants reported that CPs were helpful in justifying attendees' engagement in team formulation, prioritising

ideas and making these achievable, and providing a rationale for professionals to flexibly test ideas. There were conflicting perceptions across the teams regarding the factors that influenced the use of CPs e.g., psychologists expected CPs to be used but also reported that this was not required as attendees adopted alternative perspectives. Psychologists also reported utilising strategies to pursue the implementation of CPs.

Conclusions

This research suggests that each CMHT should agree on their expectations of the outcomes/ products of team formulation i.e., are professionals expected to use CPs, adopt alternative perspectives, or both. If CPs are expected to be utilised then CMHTs may require the support from their managers.

Practitioner Points

1. Each CMHT needs to discuss how they expect products of team formulation to be used e.g., are professionals expected to utilise CPs.
2. Clinical psychologists should reconsider if it is within their role to pursue the implementation of CPs derived from team formulation.
3. CMHTs that decide that CPs should be utilised should be provided with the resources and support for this to occur. Team leaders and service managers should take an active role in supporting their team members in this.

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This paper is written in preparation for the Psychology and Psychotherapy: Theory, Research and Practice journal. The journal specifies that all contributions should be typed in wide margins and double spacing. All guidelines outlined by the journal have been adhered to in the write up of this paper.

Introduction

The British Psychological Society (BPS) and the Division of Clinical Psychology (DCP) encourage clinical psychologists to help their multidisciplinary team (MDT) colleagues when they experience challenges in their clinical work (BPS, 2010; DCP, 2011; Onyett, 2007; Skinner & Toogood, 2010). One way of doing so is by inviting MDT members to team formulation, a process where they contribute to the development of a psychological formulation⁵ (e.g., DCP, 2011; Whomsley, 2010). The meeting of professionals to contribute to the process of team formulation could be understood as a community of practice (CoP). A CoP is defined as a group of people who discuss concerns and problems, with the aim of deepening their knowledge and expertise (Ranmuthugala et al., 2011; Merriam, Courtenay, & Baumgartner, 2003; Wenger, 2000). At the heart of a CoP is what is described as its 'domain' (Wenger, 1998, p. 14). This determines what participants value and believe is the fundamental purpose of the process (Wenger, 1998). Proponents of team formulation

⁵ A psychological formulation includes a working hypothesis about a client's presenting problem, describing the development and maintenance of this, encompassing a psychological theory and model and governing an intervention (DCP, 2011, Johnstone & Dallos, 2006)

including the BPS, (2010) and DCP (2011) suggest that the domain of team formulation is to broaden MDT members' psychological understanding, inform an intervention to meet clients' needs and support professionals to work effectively with their clients.

The DCP (2011) published findings regarding the benefits of team formulation, including alternative and shared understanding of clients' difficulties. An evaluation of these findings identified that these were derived from studies presenting with significant methodological flaws. The validity and credibility of the findings is brought into question because of the lack of reporting on the methodology used (e.g., Berry, Barrowclough, & Wearden, 2009; Craven-Staines, Dexter-Smith, & Li, 2010; Hood, Christofides, & Johnstone, 2014; Ingham, 2011; Murphy, Osborne, & Smith, 2013; Summers, 2006; Wainwright & Bergin, 2010). These cited articles present with vague content regarding the interview schedules and measures used. Consequently, bringing into question the construct validity of the questions used to derive findings.

Furthermore, three studies by Berry et al. (2009), Ingham (2011) and Robson and Quayle (2009) may have been influenced by social desirability factors. This is

considered as participants were requested to report on their perceptions of team formulation between one to six hours following engaging in the process. Although, it is likely that the proximity of this process may have aided recall, the short time spans may have limited the ability to capture the impact of team formulation on clinicians' practice. It would have been beneficial to track the influence over time.

A significant limitation of the findings reported by the DCP is that most of the studies had the involvement of the consultant, trainee or assistant psychologist who had a working relationship with the participants (e.g., Craven-Staines et al., 2010; Hood et al., 2013; Ingham, 2011; Murphy et al., 2013; Robson & Quayle, 2009). The involvement of the team's psychologist could have impacted on the process of data collection and analysis, influencing the validity of the findings.

These methodological issues have not been highlighted by the DCP resulting in these findings being presented out of the studies' context. In summary, team formulation is reported in the DCP (2011) as significant within the profession of clinical psychology; however, it may be

argued that this is being promoted beyond its established utility.

A literature review was undertaken to evaluate the research evidence of team formulation within Community Mental Health Teams⁶ (CMHTs). Three studies were found that considered CMHTs' perceptions regarding engaging in this process (Craven-Staines et al., 2010; Hollingworth & Johnstone, 2014; Hood et al., 2013) and only Hood et al.'s (2013) solely focused on CMHT participants. These three studies focus on the benefits of team formulation as related to clinical psychologists' role. For instance, Hood et al.'s (2014) CMHT professionals' reports focused on the benefits of team formulation in providing a favourable, alternative to psychiatric diagnoses. These benefits were associated with the clinical psychologist's role. It is possible that these findings may be related to protecting clinical psychologists' professional identity. Rees, Huby, McDade and McKenchie (2004) and Onyett (2007) identified that working within CMHTs led professionals to be protective of their professional identities due to threats of role blurring. It is possible that the positive bias in the evidence of team formulation within CMHTs is aimed at

⁶ Includes specialist CMHTs e.g., Assertive Outreach and Early intervention for Psychosis.

maintaining clinical psychologists' positive professional identity (Wright, 2012).

Policy papers (e.g., DCP, 2011) and researchers (e.g., Hood et al., 2014) that discuss team formulation within CMHTs do not consider the challenges faced when utilising the outcomes/ products of team formulation. Rees et al. (2004) found that CMHT professionals resisted undertaking particular tasks as they held fears that their professional identities may become blurred and merged with others. They found that CMHT professionals chose to undertake tasks that they believed were consistent with their roles. Rees et al. (2004) and Onyett (1995, 1997) found that other factors that impacted on consolidating new practice included limited resources, poor managerial support and limited understanding of the purpose of the practice. Therefore, it can be assumed that the DCP (2011) and the BPS (2010) authors neglect discussing the challenges that may be experienced by professionals when utilising the outcomes of team formulation.

The challenges experienced in CMHTs have not generally been explained using a theoretical framework, however, the psychological construct regarding mental

models drawn from business and educational literature can assist in interpreting these findings. The theory of mental models suggests that team members are able to effectively integrate new practice if they hold common or overlapping knowledge relating to the task and team work mental models (e.g., Klimoski & Mohammed, 1994). Task work mental models are defined as knowledge held by team members and their managers regarding the goal of the task, resources and processes required to undertake a task. Whereas, team work mental models are defined as knowledge held by the team members and their managers regarding the team members' tasks, role and responsibilities, expectations and abilities in relation to the task (Cannon- Bowers & Salas, 2001). Researchers found that communication between team members and managers was key in enabling team members to share similar knowledge with each other and their managers regarding the task and team work mental models (e.g., Cannon-Bowers & Salas, 2001; Mohammed & Dumville, 2001). These studies indirectly assessed these factors by undertaking observational methods aimed at understanding the impact of dissimilar mental models on the effectiveness of a task or practice (e.g., Lim & Klein, 2006). Therefore, the challenges experienced within CMHTs when faced with new practice may develop from

a lack of shared mental models amongst professionals and their managers, in conjunction with their professional identities, roles and responsibilities and ways of undertaking this practice. The theory of mental models might suggest that the utilisation of the outcomes of team formulation may not be straightforward, as its supposed benefits could be threatened by inadequacies of information or lack of communication between professionals. This study aimed to understand how CMHT professionals perceive the outcomes or products of team formulation and the factors that may influence this.

Research Questions

This paper addresses the following research questions⁷, namely, (1) what are considered helpful or unhelpful aspects of the outcomes of team formulation and (2) what factors may influence these outcomes. These questions were left open with no prior criteria so not to limit data collection and analysis.

⁷ The research questions addressed in the extended paper focused on participants' perceptions of engaging in the team formulation meeting.

Method

Research Design

An inductive qualitative design was used as it suited the exploratory and open research questions. Individual interviews with psychologists and focus groups with attendees of team formulation were conducted. This was to manage the potential influence of psychologists' participation on other professionals' discussions, as psychologists are often facilitators of team formulation (e.g., Lake, 2008b; Preedy, 2008).

Procedure

A semi-structured interview schedule was developed to guide and open up dialogue during the focus groups and interviews. The questions on this schedule were aimed at understanding what participants perceived as being helpful and unhelpful aspects of team formulation, team formulation influence on clinical practice and factors that may influence the process and outcome of team formulation. Furthermore, a topic list was developed by extracting the main themes of the interview schedule.

This was shared with participants in the focus groups and interviews to help orientate them to the topic.

CMHT members who attended team formulation were recruited from three sites within the British National Health Service (NHS). Psychologists were initially contacted about the study, and if interested they distributed study information to their colleagues. Table 8a and 8b presents demographic information of the convenience sample of the 12 professionals who participated in this study. The sample included three groups of mental health professionals who participated in one of three focus groups (Team A, B & C) and three psychologists who participated in one of three individual interviews (Psychologist John, Thomas & Rose).

Table 8a

Focus Group Participants' Demographic Information

	Pseudonym	Profession	Service	Last attended team formulation	Period of attending team formulation
Team A	Lisa	Community psychiatric nurse	Community mental health team	6 months ago	10 years
	Mary	Occupational therapist	Community mental health team	6 months ago	10 years
	David	Community psychiatric nurse	Community mental health team	1 day ago	15 years
Team B	Craig	Community psychiatric nurse	Assertive outreach	2 weeks ago	11 years
	Martha	Community psychiatric nurse	Assertive outreach	2 weeks ago	10 years
	Sally	Community psychiatric nurse	Community mental health team	2 months	2 months
Team C	Laura	Community psychiatric nurse	Early intervention for psychosis	1 month ago	10 years
	Kate	Support time recovery worker	Assertive outreach	1 month ago	1.5 years
	Jacob	Community psychiatric nurse	Assertive outreach	1 month	4 years

Table 8b

Psychologists' Demographic Information

Pseudonym	Years working as a clinical psychologist	Facilitated team formulation.
Psychologist John	15	Team formulation across community mental health team and assertive outreach
Psychologist Thomas	16	Team formulation across community mental health team and assertive outreach
Psychologist Rose	8	Team formulation across early intervention for psychosis team, crisis intervention, community mental health team.

Focus groups and interviews were held at participants' work base during usual working hours, facilitated by myself⁸ and lasted for approximately an hour. During the focus groups, participants were encouraged to discuss the topic amongst themselves, with minimal intervention from me. This approach ensured that focus group data was gathered from the interaction of the members, as recommended by focus group researchers (e.g., Kitzinger, 1995; Morgan, 1996). During the interviews, a semi-structured interviewing style was used, which included probing questions to assist psychologists to expand on their accounts (Frith & Gleeson, 2012). Both

⁸ Refers to the primary researcher

focus groups and interviews were audio recorded and transcribed verbatim.

Data Analysis

Thematic analysis was used to analyse the data and this was conducted within a contextualist, critical-realist paradigm. An inductive, mid-range semantic and latent analytical approach was undertaken, using Braun and Clarke's (2006) six-stage process. I identified the explicit and surface meaning of the data (semantic) but was also prepared to go beyond the semantic data to identify underlying ideas and assumptions. The transcriptions were initially read and re-read and initial codes were jotted down in the margins. The focus group interaction data identifying participants' interactions with each other, including agreement, were also incorporated in the analysis and coded in the margins. The initial codes were then collated into themes. Finally, a thematic table was developed presenting the main- and sub- themes.

Quality Assurance Measures

I used a range of strategies to ensure quality by establishing trustworthiness during the study (e.g., Flick

2007). These included 1) researcher triangulation which is the comparison of independently coded transcripts and themes with the second and third authors (MR & DDB), 2) keeping an audit trail throughout the analytical process to ensure transparency of the research process; 3) including verbatim quotations to enable readers to assess the credibility of findings; and 4) keeping a reflective diary to consider my influence on the research from the conceptualisation stage through to the analysis and write-up of the report.

Ethical Considerations and Approval

Ethical approval was obtained from the University of Lincoln's Ethics Committee and the Research and Development departments of two NHS trusts. During data collection, participants were informed about the voluntary nature of their participation and right to withdraw from the study. Written consent was obtained prior to participating in the interviews and focus groups. During transcription and in the write-up of the report, participants were given pseudonyms as presented in Table 8a and 8b and their identifiable details were removed to preserve anonymity.

Results

Two overarching themes were identified from the wider study of team formulation in this setting, namely, the 'outcomes of team formulation' and the 'status of team formulation'. This paper will focus on the overarching theme relating to the 'outcomes of team formulation' (Table 9). This includes original research findings regarding how ideas derived from team formulation, integrated into care plans (CPs) were viewed and how professionals' perceptions influenced the utilisation of CPs. In this section, reference to either 'psychologists' or 'attendees' indicate reports distinctively stated by either group and phrases such as 'participants' and 'professionals' identify reports that were stated by psychologists and attendees. The main- and sub-themes are presented as being distinct from each other to ease reading; however interrelationships between these will be evident.

Table 9

*Thematic table presenting the main and sub- themes
relating to the overarching theme:*

Outcomes of team formulation

Main themes	Sub-themes
Significance of Care Plans (CPs)	<i>Tangible products</i> <i>Managing overwhelming ideas</i> <i>A rationale to flexibly test ideas</i>
Life Expectancy of CPs	<i>Different expectations</i> <i>Short- or long- lived CPs</i> <i>Decision makers/ factors</i>
Perceived Value	<i>Hopeful psychologists</i> <i>Waste of time?</i>

Care plans (CPs)

Across the transcripts, participants reported that ideas derived from the process of team formulation, which were contributed by other professionals, informed clients' plans of care or "care plans" (Psychologist John, Thomas & Rose; Team A, B & C). As participants used the term "care plans" (CPs), this will continue to be used in this paper. This term should not be confused with the routine plans developed within CMHTs which are part of the Care Programme Approach (CPA). The CPs discussed in this paper differ from the CPA plans as these make up ideas derived from the process of team formulation. These CPs were identified as the products of team formulation.

Participants reported that CPs were positive because they "shifted" attendees from feeling "stuck" and assisted them to "move forward" with their clients (e.g., Team A, B & C) (as illustrated below).

Sally: = (team formulation) allowed for reflection (.) and because different disciplines reflected their thoughts through their ideas (.) the things that I had not thought about because I was really stuck with the person who I was working with

and... (.) I came out from there feeling more positive and having more clear direction (.) and a plan of where I was going because people contributed their opinions and ideas

Team B

Participants across the three teams reported the benefit of involving other professionals in team formulation, as this enabled attendees to obtain a new understanding of their clients' presentation and assisted in informing an intervention to work effectively with clients (as illustrated above). CPs were reported be helpful in alleviating professionals' feelings of being "stuck". In the following sections, participants' reports identify (1) the helpfulness of CPs, as products of team formulation and (2) conflicting perceptions are reported across the three teams regarding how CPs were viewed and how these perceptions influenced how they were used.

Significance of CPs

This main theme identifies participants' reports regarding CPs as helpful as they (1) were tangible products of team formulation, (2) helped manage overwhelming ideas and (3) provided a rationale to flexibly test ideas.

Tangible products.

Across all transcripts, participants reported that CPs were an integral aspect of team formulation, particularly as they shifted professionals from feeling “stuck” by planning ways of working with their clients. Participants stated that without a CP, engaging in team formulation would be considered “pointless” (e.g., Team B). Participants across all teams identified CPs as integral and valued products of team formulation.

Int: ... what makes a formulation helpful
or useful for everyone

Psychologist John: =care plan at the end of it (.) if
you have a formulation whereby it doesn't translate
into action then while ever it can be fun or
entertaining or intellectually stimulating (.) it would
be an abstraction (.) ... people have said (.) 'ok it's
all well and good talking about it but what does it
really mean' (.) it means a refinement of care (.) it
means understanding the service user better to
know what we are delivering is right (.) or could be
tweaked to be more effective (.) that's the whole
point of formulation (.) if you are not getting a care
plan at the end of it then I think you are then

engaging in a theoretical exercise and ...they don't feel as meaningful to the people engaging in those conversation

Kate: so it's not just about the oh yeah we've sat there and gossiped about somebody (.) you've done all that but then you're like ok (.) so how do we put them back together again and importantly what is the plan to move forward

Team C

Across all transcripts, participants reported that team formulation enabled attendees to plan clients' care in order to meet their needs and work effectively with them. As indicated in the previous extract, it is perhaps unsurprising that CPs were perceived as tangible products as they were used to justify engagement in the process. All three psychologists reported recognising this and subsequently taking responsibility to integrate CPs within team formulation.

Managing overwhelming ideas.

Psychologists also reported introducing CPs during team formulation to ensure ideas were achievable and prioritised. Psychologists reported that this was helpful

when participants felt overwhelmed by too many or unachievable ideas. In the below quotation Psychologist Rose described how the prioritisation of ideas in the CP may have occurred.

Psychologist Rose: it's kind of saying (.) 'yes let's jot the ideas down but let's put them further down the list but actually where do we need to focus on right now' (.) that can help with not feeling overwhelmed

A rationale to flexibly test ideas.

Participants reported that CPs were neither “general, one-size fits all” nor derived from “standard protocols” and that these plans were “most appropriate” for clients’ needs (e.g., Psychologist John; Team A, Team C). These plans were perceived as a vehicle in permitting staff members to stray away from their standard working practice. Attendees reported that CPs offered them a rationale to test ideas and to work in a flexible way. This is also indicated in the following extract from Jacob who spoke about being given “freedom” to work flexibly as a result of the CP.

Jacob: it's almost like a crib sheet for staff to be able to look at and say (.) yeah we've tried that we haven't tried that and it also gives you the freedom to try something you've already tried ...(.) it gives you the confidence to be able to try that again because the circumstances around the patient are different

Team C

The term “freedom” appears positive and suggests that CPs provided flexibility to work outside of normal practice. Furthermore, Jacob reported that it gave him “confidence” in repeatedly testing out ideas at different times, implying that the plan may have justified practice that would not be undertaken otherwise.

This main theme addressed the research question regarding what professionals deemed as helpful or unhelpful aspects of the outcomes of team formulation. CPs were said to be helpful in (1) providing tangible products of team formulation, (2) managing overwhelming ideas and (3) providing a rationale to flexibly test ideas. Participants did not report unhelpful aspects of CPs as products of team formulation.

Life Expectancy of CPs

This main theme presents conflicting perceptions reported across the three teams regarding how CPs were viewed and how these perceptions influenced their utilisation.

Different expectations.

Participants reported that CPs were perceived as either “intervention plans” or “list of ideas” (e.g., Psychologist Rose; Team C). When CPs were said to be “intervention plans”, participants reported imminently implementing these, whereas “lists of ideas” had no expectations to be implemented. This indicates two diverging perceptions of CPs and how these may have influenced their immediate utilisation.

Short- or long- lived CPs.

Participants’ reports also suggested that the life expectancy of CPs was short-lived (as illustrated below).

Jacob: it’s almost like it’s there (CP) but (.)
we’ve done it now and then we put it away

Laura: yeah

Jacob: ... somebody else coming and
picking up the file and the notes (.) wouldn't know
it was there

Team C

As indicated in the extract above, there were consistent reports from participants that suggested that constructing a CP was the concluding task of team formulation.

Although professionals reported that the process of formulating was ongoing and a “work in progress” (e.g., Team C; Psychologist Rose), they also reported that CPs were not revisited. This was because (1) revisiting CPs had not been integrated in the process of team formulation, (2) other professionals would be unaware of the CP unless they were part of the meeting and (3) professionals were too busy to read the CPs (e.g., Psychologist Thomas; Team C).

There was a consistent pattern of participants' reports describing revisiting CPs as an “extra demand” and a “low priority” (e.g., Psychologist Thomas, Rose; Team A, C). Participants reported that they were not committed or engaged in revisiting CPs.

Decision makers/ factors.

Participants across the three teams reported that attendees, mainly the care-coordinators, decided if they were to utilise the CPs. Across all transcripts, participants reported that care-coordinators only had a choice to implement CPs, if these were considered “lists of ideas”. Professionals reported that when care-coordinators had a choice to utilise CPs they considered their appropriateness, feasibility, skills, resources, importance, risk and support of the team. Although responsibility in deciding whether to undertake CPs was reported to be mainly the care-coordinators, Psychologist Rose reported that this was also the team’s responsibility.

Psychologist Rose: because it has been written collectively ... we all did this (.) we are all collectively in this (.) we all haven’t done it

This implies that there may be potential consequences for staff members who may not implement CPs leading to a diffusion of responsibility. In contrast to this, Team B reported that they were unable to utilise CPs due to service restrictions that impacted on their roles and responsibilities. This discussion is presented below.

Craig: ... as our team has evolved over the years that question has become more and more important (.) you know what do we do with these (.) we've changed (.) our role has changed (.) our role has diminished with our clients (.) from a time when ten years ago or so when we had pretty much a full range and a full reign even of what we could do with that information (.) to now saying you can't do that you can't do that (.) because that's not your role anymore that is somebody else's role ... there just didn't seem to be any boundaries at one point (.) but the boundaries are a lot more rigid now in terms of what we can do and so the formulation itself (.) although still useful it doesn't offer us the freedom to use that information as much as it used to

Mod: so who has set these boundaries

All: services

Team B

The extract implies a conflict in attendees feeling restricted and wanting to utilise CPs. Attendees' reports imply that blame for not utilising CPs is attributed to the

service rather than themselves, presenting themselves as helpless and powerless.

This main theme addressed the research question regarding the factors that may influence the outcomes of team formulation. There were conflicting perceptions across all transcripts regarding views of CPs as either “intervention plans” or “lists of ideas”, whether a CP was perceived as a concluding or an ongoing task, attendees’ control in implementing CPs derived, the influence of the service and potential diffusion of responsibility. These factors were reported to then affect the immediacy and attendees’ ability to utilise CPs.

Perceived Value

This main theme presents psychologists’ hopefulness of the utilisation of CPs and participants’ perceptions of CPs that were not utilised.

Hopeful psychologists.

Psychologists reported that they were unaware of the utilisation of CPs as they did not systematically evaluate them but held hope that these were being implemented.

Most of the psychologists reported that if CPs were not undertaken then attendees were providing “inadequate, inappropriate service to their clients” (e.g., Psychologist John). As indicated in the theme relating to the significance of CPs, attendees also reported feeling that their standard practice was sometimes “inappropriate” for their clients’ needs (e.g., Team A; Team C). Furthermore, psychologists reported utilising strategies to pursue the implementation of CPs, including modifying ideas to be more achievable, justifying ideas as part of attendees’ professional role and offering joint work. If these strategies were unsuccessful, psychologists reported abandoning pursuing the implementation of particular CPs.

Waste of time?

There were frequent reports from psychologists regarding their frustration when attendees did not implement CPs.

Psychologist Rose: ... in the team meetings (.)
when things crop up and you think we’ve done this
(.) take a deep breath and you go ((*laughter*)) (.)
‘ok I’m sure we’ve got something like this do you
want to have a quick look’ then I’ll bring it back and

say (.) 'oh isn't it interesting' ra ra ra she says you
know seething inside ((*laughter*))

The above quotation is consistent within psychologists' reports regarding not expressing their frustration with their colleagues. The controlled way of managing their frustration, such as by taking a deep breath, suggests that expressing this may have been unhelpful or unacceptable. Attendees did not explicitly report particular emotional experiences regarding not utilising CPs.

All three psychologists associated their frustration with the effort they contributed to the process. They reported that unimplemented CPs indicated that team formulation had been "a waste of time" and therefore expected CPs to be used (e.g., Psychologist John, Rose & Thomas). It is unclear whether psychologists' frustration may also be associated with perceptions regarding CPs as "intervention plans" rather than "lists of ideas". This is brought into question because a perception of CPs as "intervention plans" may have led to an assumption that expectations of immediate implementation were not being met; therefore, eliciting feelings of frustration. In contrast to this, psychologists and attendees reported that despite

CPs not being acted on, they felt that team formulation had not been a waste of time as attendees had opportunities to challenge their thinking. Participants reported that engaging in team formulation provided valued opportunities to consider alternative perspectives, often described as a “fresh focus” or “food for thought”, therefore CPs were not required to be used (e.g., Psychologist Rose; Psychologist Thomas; Team A).

This main theme addressed the research question regarding what participants considered helpful and unhelpful aspects of the outcomes of team formulation. This theme identified the conflicting assumptions made across participants’ reports regarding ideas that were not utilised. Psychologists expected CPs to be used but also reported that this was not required as attendees adopted alternative perspectives; whereas attendees only reported the latter. This theme also identified psychologists’ frustration when CPs were not utilised.

Discussion

This study makes original contributions to our understanding of the outcomes of team formulation. In relation to these findings, reference to previous literature

and theoretical frameworks, implications for clinical practice and future research will be discussed. In conclusion, an evaluation of the study will be presented.

Reference to Previous Literature

Significance of CPs.

This main theme addressed the research question regarding what professionals considered as helpful or unhelpful aspects of the outcomes of team formulation, by further elaborating on the use of CPs. Two articles on team formulation report the need for CPs to be constructed during team formulation and the psychologists' role in doing so (Jackman, 2013; Shirley, 2010). However, both these articles are written based on the opinion of clinical psychologists rather than published evidence base. Across three studies there appears to be agreement that the development of plans during team formulation may be an important and useful outcome (Hollingworth & Johnstone, 2014; Murphy et al., 2013; Wainwright & Bergin, 2010). My study broadens the understanding of plans developed during team formulation by highlighting other helpful functions of CPs including (1) providing tangible outcomes of team

formulation, (2) helping to manage overwhelming ideas and (3) providing a rationale to flexibly test ideas. This main theme also identified CPs as integral outcomes of team formulation. Participants did not report unhelpful aspects of CPs.

Life expectancy of CPs.

This main theme addressed the research question regarding the factors that may influence the outcomes of team formulation. The study identified conflicting reports across the transcripts regarding (1) perceptions of CPs and their immediate utilisation, (2) staff members' choice and their responsibility regarding the utilisation of CPs and (3) service influences on the ability to utilise CPs. Shirley (2010), a clinical psychologist who facilitated team formulation, wrote an article outlining her expectations that CPs would have an ongoing impact on professionals' practice. To date, only one article by Walton (2011) reported that 46% of recommendations made during team formulation were either attempted or completed, however reasons for this were not identified. This study provided an original understanding of the conflicting perceptions held by participants when faced with utilising CPs.

Perceived value.

This main theme addressed the research question regarding what was considered helpful and unhelpful aspects of the outcomes of team formulation. It identified original findings relating to psychologists' and other professionals' divergent reports of the value of this process. To date there has been one study that has reported professionals' perceptions that those who did not utilise CPs were providing inadequate and inappropriate service to clients (Hood et al., 2013). However, Hood et al. (2013) and the current study lacked further detail regarding this claim. With regards to the value of adopting alternative perspectives, there are studies that have found that alternative perspectives of challenging clients often led to changes in professionals' emotion and attitude towards their clients (e.g., Dagnan, Trower, & Smith, 1998; Hill & Dagnan, 2002). However, only three articles have reported on changes in professionals' perceptions following team formulation, with two having used quantitative methodology whereby they analysed pre- and post- data relating to professionals' perceptions (Berry et al., 2009; Ingham,

2011) and Wainwright and Bergin, (2010) utilising a mixed- methodology.

The findings regarding psychologists' strategies in pursuing CPs and their frustration regarding this process are novel contributions to research. Articles have reported that psychologists often take a facilitative role in team formulation (e.g., Hood et al., 2013; Murphy et al., 2013; Summers, 2006). It is perhaps not surprising that psychologists reported feeling frustrated when CPs were not implemented, as they also believed they contributed a lot during this process. Although there is limited evidence regarding psychologists' experiences relating to CPs, recommendations have been made stating that psychologists should utilise supervision and training to manage difficulties experienced during team formulation (e.g., Lake, Solts, & Preedy, 2008).

Relation to literature on expected outcomes.

This study identified that CPs were integral and valued outcomes of team formulation, as these informed interventions to meet clients' needs and supported professionals to work effectively with their clients. These outcomes are reported as expected in articles regarding

team formulation (e.g., Lake, 2008a; Whomsley, 2010).

Participants did not report on broadening their psychological understanding following team formulation, and this did not meet expectations of team formulation (e.g., DCP, 2011).

Theoretical Implications

Mental models

If effectiveness of team formulation is based on the use of CPs then the theory of mental models would predict that participants in this study hold dissimilar team and task work mental models with each other and their managers, therefore influencing the use of CPs. The theory of mental models would predict that the different expectations regarding the use of CPs would then affect professionals' decision making regarding utilising CPs in their clinical work. With regards to the effectiveness of team formulation based on the use of CPs, this is a problematic area as an agreement of what is considered effective with regards to the use of CPs was not ascertained by participants. Psychologists expected CPs to be used but also reported that this was not required as attendees adopted alternative perspectives; whereas

attendees only reported the latter. It should be noted that psychologists and attendees both agreed on the value of alternative perspectives and the significance of CPs. According to the theory of mental models it would be considered that participants held shared mental models regarding this, although there were dissimilar mental models regarding the use of CPs.

A way of understanding why the mental models regarding the use of CPs may not been shared is to use Wenger's (1998, 2000) psychological construct of 'communities of practice' (CoP). This construct helps us to understand the potential function of team formulation within CMHTs and why a shared mental model regarding the significance and helpfulness of CPs may be held in conjunction with a dissimilar mental model regarding the utilisation of CPs.

Communities of practice (CoP).

Participants reported that CPs were integral in supporting professionals from feeling less "stuck" as this helped them plan ways of working effectively with their clients and meet their needs. Participants identified other professionals' participation as contributing to a new understanding or alternative perspective of their clients.

This is in line with CoP fundamental assumption that knowledge is acquired by interacting with others (e.g., Li et al., 2009; Merriam et al., 2003; Wenger, 2000).

Using the knowledge gained from CoP is not mandatory but is determined by each member (Wenger et al., 2002). Each member chooses what they take from their experience and considers how this knowledge may be applied in their practice (Wenger, 1998, 2000).

Understanding team formulation as a CoP may explain the conflicting perceptions regarding the use of CPs as a reflection of the factors that professionals consider when faced with utilising CPs. Furthermore, this can help us understand why participants in this study may not have discussed having broadened their psychological understanding as this would depend on each professional's needs.

CoP are only important for an organisation when the knowledge gained is recognised as a key asset (e.g., Merriam et al., 2003). Discussions between managers and CoP are needed to provide support for knowledge to be utilised within organisations (e.g., Ranmuthugala et al., 2011). Although participants in this study reported that CPs would enable them to provide their clients with an

adequate and appropriate service, service managers may need to support and approve of the utilisation of the CPs.

Clinical Implications

This research suggests that each CMHT should discuss and agree on what they expect should be the outcome of team formulation, e.g. are professionals expected to undertake CPs, adopt alternative perspectives, or both.

1. If the team values adopting alternative perspectives then they should consider how this could continue to be attained e.g., encouraging other professionals to participate in the process.
2. If the team believes that CPs should be utilised then discussions with service managers should be undertaken and the following should be considered.
 - Resources and support required to undertake CPs e.g., during team formulation participants could discuss barriers they foresee in implementing the CPs and ways of managing these.

- Service restrictions in implementing CPs and ways of managing this.
- Ways of monitoring this progress should be considered e.g., if it is agreed that CPs would require ongoing updating then appropriate measures would need to be determined to support this.
- Discussion regarding who will be accountable for CPs would need to be undertaken and agreed with the team e.g., is it the team's responsibility or care-coordinators'.
- Roles and responsibilities of team members should be discussed e.g., it should be questioned if it is within psychologists' responsibilities to ensure that CPs are implemented.

In conclusion, psychologists should consider organising forums such as group supervision to voice and discuss challenges experienced in team formulation.

Research Implications

Due to the limited research evidence regarding the outcomes of team formulation, recommendations for future research are discussed.

1. This study identified the various functions of CPs.

However this study did not consider whether other plans of clients' care derived from meetings without team formulation also lead to similar functions. This needs to be addressed as it would enable us to understand the unique aspects, if any, of CPs.

2. This study relied on participants' reports which may have included retrospective biases. It may be useful for researchers to undertake follow-up observational studies to investigate the utilisation of CPs following their construction. Mixed method studies could be undertaken in which professionals could report on the reasons for their utilisation or lack of, at specific time points. Demand characteristics may influence this and would need to be considered in research designs.

3. Participants discussed that team formulation enabled appropriate and adequate interventions compared to those derived from 'standard protocols'. Researchers should compare interventions from team formulation

and another meeting where clients' care is discussed to assess the adequacy and appropriateness of these interventions.

4. Participants reported on the value of adopting alternative perspectives during team formulation. Researchers should consider gathering qualitative and quantitative data relating to participants' attitudes and emotions towards the client over a longer period of time after team formulation. Outcome measures regarding professionals' stress levels and attitudes towards clients could be developed for this.

Evaluation

Utilising a qualitative approach led to a rich and in-depth understanding of the outcomes of team formulation. The combination of individual interviews and focus groups meant a wider breadth of data could be collected and TA allowed for an in-depth analysis of the data. Participants' perceptions could be represented by utilising an inductive, mid range semantic and latent analytical approach. Furthermore, the trustworthiness and credibility of the findings was ensured by using a number of quality assurance measures. In spite of these strengths, a number of limitations must be considered.

Generalisability of findings is limited because of the small sample of 12 recruited using purposive sampling. It cannot be assumed that the findings can be representative of CMHT professionals in other teams, without future research being undertaken. The epistemological stance adopted in this research posits that these research findings have some truth, however it is suggested that a larger, more geographically diverse sample could ensure greater representativeness and may clarify the research findings.

The focus groups could have led to 'censoring' of opinions resulting in a false impression of conformity. It is difficult to ascertain that this did not occur as participants' working relationships may have influenced this. Additional interviews with focus group participants could have supported alternative views to emerge.

In conclusion, my role as a trainee clinical psychologist may have led to social desirable responses. Other researchers should consider employing non-psychologists to undertake data collection to manage this.

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EXTENDED PAPER

EXTENDED INTRODUCTION

This section expands on the journal paper. It provides an overview of the relevant literature, which informs the research aim and questions.

Team Formulation

The British Psychological Society (BPS) and Division of Clinical Psychology (DCP) encourage clinical psychologists to help multidisciplinary teams (MDTs) when they experience challenges in their clinical work (BPS, 2010; DCP, 2011; Onyett, 2007; Skinner & Toogood, 2010). One way of providing this support is by inviting MDT members to contribute to the development of a psychological formulation (e.g., DCP, 2011; Whomsley, 2010). A psychological formulation includes a working hypothesis about a client's presenting problem, describing the development and maintenance of this, using a psychological theory and model to govern an intervention (DCP, 2011, Johnstone & Dallos, 2006). The process by which MDT members are invited to contribute to a psychological formulation is variously referred to as formulation meetings, shared formulation, complex case formulation and team formulation, the latter term will be used in this paper to ease reading (e.g., Davenport, 2002; DCP, 2011; Whomsley, 2010). Proponents of team formulation have outlined expectations that this process would support professionals to work effectively with their clients, to inform an intervention to meet clients' needs and to broaden MDT members' psychological understanding (e.g., BPS, 2010; Christofides, Johnstone, & Musa, 2011; DCP, 2011; Green, Potter, & Wilcox, 2013; Onyett, 2007).

An alternative to psychiatric diagnoses.

Clinical psychologists have criticised psychiatry for dominating the mental health system and presenting a biomedical model of mental distress, resulting in the use and application of psychiatric diagnoses and diagnostic systems (Boyle, 1999; DCP, 2013; Johnstone, 2000; Newnes, 1999; Newnes, Holmes, & Dunn, 1999; Pilgrim & Treacher, 1992; Thomas, 2014). This section evaluates psychiatric diagnoses and their diagnostic systems and describes how team

formulation offers an alternative method of understanding individuals' emotional distress; which is favoured by clinical psychologists and other mental health professionals (e.g., DCP, 2013; Hood, Christofides & Johnstone, 2014; Johnstone, 2000).

Psychiatric diagnoses are determined by clustering individuals' symptoms of emotional distress (Boyle, 1999). These diagnoses have been found to be common language for mental health professions, clients and the general public (e.g., Jablensky & Kendell, 2002; Regier, First, Marshall, & Narrow, 2002). However, it is considered that these are merely labels given to represent individuals' presenting difficulties, without offering an understanding of the aetiology and maintenance of their experiences (e.g., Macneil, Hasty, Conus, & Berk, 2012). Some clients find such diagnoses as validating and a way of normalising their experiences, as it may be considered that other people may hold similar diagnoses (Corrigan, 2007). On the other hand, psychiatric diagnoses can maintain individuals' difficulties, coined as "circular logic" (Pilgrim, 2000; p. 303), lead to stigmatisation, discrimination and disempowerment (e.g., Campbell, 2007; Corrigan, 2007).

Psychiatric diagnostic systems are used to determine psychiatric diagnoses, however, problems have been found regarding their attempt to draw from classification procedures used within medical systems. A medical diagnosis includes the process of matching an individual's pattern of symptoms and biological signs to a standard pattern in the classification, ensuring that similar but alternative patterns are discounted in the matching – the process of differential diagnosis (Boyle, 1999; DCP, 2013). The patterns themselves are commonly categorical; if it is one it cannot be the other, but several can co-occur (co-morbidity) (DCP, 2013). However in psychiatry it has been found that individuals' 'symptoms' cannot be exclusively differentiated from other categories, resulting in different professionals concluding different diagnoses for the same symptoms (Boyle, 1999; DCP, 2013). The regular revision of the two major psychiatric classification systems, the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* and the *International Classification of Diseases: Classification of Mental and Behavioural Disorders (ICD)* brings into question

the validity of psychiatric diagnoses, particularly as some of these can be removed from systems after having been applied. For example, homosexuality was classed as a mental health disorder until 1974 where it was voted out of the *DSM* (Newnes, 1999). This diagnosis also functioned as a method of social control which resulted in stigma and discrimination for those who carried this diagnosis (Newnes et al., 1999).

Boyle (1999) outlines that the most appropriate alternative to psychiatric diagnoses would need to offer the following:

- Help in understanding and explaining individuals' experiences;
- Consider what individuals actually experience rather than taking into account a hypothesized behaviour;
- Consider the social and interpersonal context of individuals in relation to their experiences;
- Assist in understanding the meaning and function of individuals' experiences and their behaviour;
- Acknowledge that people actively construct their behaviour and experiences and although distressing for them and others, these may be coping strategies;
- Shift the problem from being perceived as within the person by acknowledging factors that may be maintaining this.

The DCP (2011, 2013) documents team formulation as an alternative to psychiatric diagnoses, as it invites MDT members to construct psychological formulations. Psychological formulations provide an understanding of individuals' experiences by adopting a multi-factorial approach that contextualises distress and behaviour and acknowledges the complexity of the interactions involved in human experience (DCP, 2013; Johnstone, 2000). It helps us to understand an individual's experience as "whole-person and whole-system" and examines the potential function and meaning of this experience (Johnstone, 2000). As psychological formulation is reported to be a core skill for clinical psychologists, it is considered that as they facilitate team formulation, this process can enable MDT members to adopt an alternative understanding of

their clients' difficulties (DCP, 2011; Management Advisory Service [MAS], 1989; Onyett, 2007; Skinner & Toogood, 2010). The DCP (2011, p. 9) states that using team formulation within MDTs is an effective and "powerful" way of shifting a cultural change dominated by psychiatry, as it promotes a biopsychosocial understanding of clients' difficulties.

Clinical psychologists' role in broadening MDTs' psychological knowledge.

Amongst other purposes, team formulation is also expected to broaden MDT members' psychological understanding and it is believed that it is within clinical psychologists' role to support this (DCP, 2011; Christofides et al., 2011; Lake, 2008a; Onyett, 2007). It is argued that MDT members have limited psychological knowledge as their training may have restricted this (Johnstone, 2000; MAS, 1989; Onyett, 2007). Projects such as those undertaken by Management Advisory Service [MAS] (1989) and DCP (2007) report on the distinctive skills that clinical psychologists hold. They outline that clinical psychologists are skilled in theorising, analysing and making suggestions about complex and a variety of psychological issues because of their broadly based psychological knowledge. Furthermore, both the BPS (2010) and DCP (2007, 2011) have claimed that clinical psychologists' broad psychological knowledge are a unique contribution to their MDT colleagues.

The focus on clinical psychologists' role within team formulation can be understood as a strategy to rebrand themselves within a changing and threatening NHS. Recent studies maintain that clinical psychologists provide distinct psychological knowledge (e.g., Hood et al., 2014). These articles both neglect other professionals' level of psychological knowledge and an increase in opportunities for psychology training that NHS professionals can engage in, to enable them to undertake psychological work (Wright, 2012). The promotion of clinical psychologists' skills within team formulation could be a way of securing their role within the NHS, particularly as they are in danger of giving away their core skills. This strategy may be focused on retaining the skills that clinical psychologists believe are unique to them.

Theoretical explanation regarding the impact of alternative perspectives adopted during team formulation.

Researchers report that team formulation offers a new understanding of clients' behaviour, particularly as it draws on a range of facets to understand the development and maintenance of individuals' problems, informing new pathways of supporting clients (e.g., Wainwright & Bergin, 2010). It is argued that this process could influence unhelpful attributions or negative emotional responses that professionals may experience towards their clients (Ingham, 2011).

Weiner's (1980, 1985) theory of attribution has been used to interpret the impact of alternatives perspective adopted during team formulation. Weiner's (1980) theory suggests that attributions held by people about behaviour displayed by another individual, influenced their responses towards that individual. The theory included three key mediators in how one perceived another's behaviour:

1. Locus - whether the cause of a behaviour is seen as internal or external to the individual displaying the behaviour;
2. Stability- the extent to which the cause was consistent each time the behaviour occurred;
3. Controllability- the extent to which the cause was under the individual's control.

If professionals held an attribution that challenging behaviour was under an individual's control and had an internal locus, then Weiner's theory would predict an emotional response of anger, less optimism for change and reduced likelihood of helping behaviour. Contrary to this, if the professional believed the behaviour to be out of the control of the individual then more sympathy would be elicited with greater willingness to help. Weiner's theory has been supported by studies that have shown that professionals experienced greater empathy, tolerance and confidence in working with their clients as a result of team formulation. This was reported to be associated with changes in professionals'

attributions of their clients as having less control of their behaviour, having the potential to improve and professionals believing that this improvement was possible (e.g., Berry, Barrowclough, & Wearden, 2009; Ingham, 2011; Wainwright & Bergin, 2010). As researchers assessed changes in professionals' attributions immediately following the team formulation, it is unknown of the long term impact of the alternative perspectives adopted. Although three studies in total have applied this theory to interpret this finding (Berry et al., 2009; Ingham, 2011; Wainwright & Bergin, 2010), Weiner's theory of attribution helps us to understand the potential implications of alternative perspectives gained from team formulation.

Team formulation: Research Evidence

Articles on team formulation mainly focus on two themes, namely, supporting psychologists in facilitating these meetings and promoting team formulation by reporting its benefits.

A large amount of articles on team formulation are aimed at supporting clinical psychologists facilitate these meetings. In these articles psychologists highlighted strategies and frameworks that may be useful in this process. A variety of strategies used by psychologists were presented, ranging from informal ways of working, whereby hypotheses are suggested as part of a discussion (Christofides et al., 2011) to more explicit methods, using structured case presentations (Whomsley, 2010). The strategies used were reported to depend on the team culture; the psychologist's relationship with the team and how the psychologist and the service define the psychologist's role (Christofides et al., 2011; Preedy, 2008; Shirley, 2010; Whomsley, 2010). Furthermore, psychological models and frameworks that could be utilised during this process were identified (Berry et al., 2009; Davenport, 2002; Dexter-Smith, 2010; Jackman, 2013; Lake, 2008b; Rowe & Nevin, 2013; Shirley, 2010). For example, Dexter-Smith (2010) introduced a modified cognitive behavioural therapy framework that included biological concepts. Dexter-Smith (2010) reported that this biopsychosocial framework had been successfully utilised in inpatient and community mental health settings, enabling staff members to

increase their understanding of their clients' presenting difficulties. Although these articles identified ways psychologists could manage the facilitative role in team formulation, these articles drew on personal experience rather than a published evidence base.

The DCP *Good Practice Guidelines on the use of psychological formulation* claims 17 benefits of engaging in team formulation (Table 10). This may be both related to the methodology employed within these studies that may have inhibited participants' reports and the influence of the DCP (as discussed in the following section).

The claims regarding the benefits of team formulation are presented by the DCP. The DCP's position as marketing for the profession should not be underestimated (see DCP, 2007 for marketing strategy). Furthermore, the main authors of the DCP (2011) document are the main promoters of team formulation (e.g., Using formulations in teams, 4.7.14, BPS Offices). It is possible that both the underlying values of the DCP and allegiance of the DCP (2011) authors may have influenced the way information is presented in this document. An evaluation of the benefits claimed in this document was undertaken to ascertain the validity of these findings.

Table 10

Benefits of team formulation claimed by the DCP, 2011, p. 9

Enables a shared understanding of a service user's difficulties.
Achieves a consistent team approach to intervention.
Helps the team, service user and carers to work together.
Helps gather key information in one place.
Helps generate new ways of thinking.
Helps deal with core issues (not just crisis management).
Leads to an understanding of attachment styles in relation to the service as a whole.
Provides support for team members working with service users who are perceived as complex and challenging.
Draws on and values the expertise of all team members.
Challenges unfounded 'myths' or beliefs about service users.
Reduces negative staff perceptions of service users.
Helps process staff counter-transference reactions.
Helps staff to manage risk.
Helps minimise disagreement and blame within the team.
Helps increase team understanding, empathy and reflectiveness.
Helps raise staff morale.
Helps convey meta-messages to staff about hope for positive change.

Following an evaluation of the 11 articles that the above claims are based on, I found that some of these claims are not justified. Five of these articles were clinical psychologists' personal reports of engaging in team formulation rather than published evidence base (Clarke, 2008; Lake, 2008a; Kennedy, 2009; Walton, 2011; Whomsley, 2010). Furthermore, one study by Christofides, Johnstone and Musa (2011) presented the assumed impact of team formulation, reported by clinical psychologists. The kind of evidence reported in the cited studies cannot be used to support the causal claims listed above.

In addition to the remaining five articles that the above claims were based on (e.g., Berry, Barrowclough & Wearden, 2009; Craven-Staines, Dexter-Smith & Li, 2010; Hood, Johnstone & Christofides, 2013; Summers, 2006; Wainwright & Bergin, 2010), a literature review identified four other studies that had aimed to evaluate team formulation (e.g., Hewitt, 2008; Ingham, 2011; Murphy, Osborne & Smith, 2013; Robson & Quayle, 2009). Therefore, a total of nine studies were found that discussed the impact of team formulation among MDTs indicating that this is an under-researched practice.

There may be limited research on team formulation for two reasons in particular.

The first potential reason is that clinical psychologists' role of working within MDTs is relatively new and this has not kept up with undertaking research in this area (Onyett, 2007). The fast paced development of the profession and the ever increasing responsibilities of clinical psychologists may be limiting the time and resources they have to undertake research in team formulation (Onyett, 2007; Wright, 2012).

The second potential reason is that there remains limited research evidence for formulation on a broader level, which neglects the importance of undertaking research on team formulation (e.g., Onyett, 2007; Wright, 2012). The limited research evidence on team formulation is following suit because the broader issue regarding limited research evidence on formulation has not been addressed. Therefore, clinical psychologists may be driven to undertake team formulation, despite its limited research evidence, as this expectation is documented in their practice documents.

The validity and credibility of the findings from the nine articles is brought into question because of limited information regarding the methodology used (e.g., Berry et al., 2009; Craven-Staines et al., 2010; Hood, Christofides, & Johnstone, 2014; Ingham, 2011; Murphy et al., 2013; Summers, 2006; Wainwright & Bergin, 2010). None of the articles detailed either the interview schedules or the items used in the measures, but instead outlined overarching

topics and limited information on the items. The vagueness of the interview schedules and measures makes it difficult to assess the construct validity of the questions used to derive findings.

Furthermore, three studies by Berry et al. (2009), Ingham (2011) and Robson and Quayle (2009) may have been influenced by social desirability factors. Participants were requested to report on their perceptions of team formulation between one to six hours following engaging in the process. Although it is likely that the proximity of this process may have aided recall, the short time spans do not capture the impact of team formulation on clinicians' practice. It would have been beneficial to track the influence over time.

A significant limitation of five of the nine studies is the involvement of the consultant, trainee or assistant psychologist who had a working relationship with the participants (e.g., Craven-Staines et al., 2010; Hood et al., 2013; Ingham, 2011; Murphy et al., 2013; Robson & Quayle, 2009). The involvement of the team's psychologist could have impacted on the process of data collection and analysis, influencing the validity of the findings. This could also explain the lack of participants' reports regarding negative or unhelpful aspects of engaging in team formulation. Furthermore, some of the studies used vignettes and drew from these findings regarding team formulation with actual clients, bringing into question the external validity of these findings (e.g., Ingham, Clarke & James, 2008). Unfortunately, these flaws have not been highlighted by the DCP resulting in these findings being presented out of the studies' context. This implies that team formulation is being promoted beyond its established utility.

This study made attempts to deal with the methodological issues that had been identified in previous studies of team formulation. This included having a clear outline of the research process to ensure transparency, utilising methods of data collection that would minimise the influence of the researcher such as the use of a topic list, undertaking focus groups and collecting data from participants that I had no working relationships (see Extended Methodology).

Team formulation and Community Mental Health Teams⁹ (CMHTs)

Challenges in CMHTs.

Despite the promotion of team formulation, there remains insufficient literature relating to this process within Community Mental Health Teams (CMHTs). Only three studies have considered CMHTs' perceptions of team formulation (Craven-Staines et al., 2010; Hollingworth & Johnstone, 2014; Hood, Johnstone, & Christofides, 2013) and only Hood et al.'s (2013) study solely focused on CMHT participants. There are reasons to assume that CMHTs may function differently to inpatient teams. Johnstone (2000) reports that CMHTs are not as driven by psychiatry compared to inpatient settings; but rather a psychosocial model which supports mental health professionals to feel more independent in their professional roles and consider psychosocial interventions.

The three studies that considered CMHT participants have issues regarding the validity of their findings. The researchers mainly focused on the benefits of team formulation and unhelpful aspects of team formulation were not identified. This may be a result of an implicit bias of having the team's psychologist undertaking the data collection, as indicated in Hollingworth and Johnstone's (2014) and Hood et al.'s (2014) studies.

Furthermore, Hood et al. (2014) study neglects other professionals' engagement in team formulation. This study focuses on both comparing team formulation against psychiatric diagnoses and clinical psychologists' role in team formulation. These findings may aim to promote the 'added value' of clinical psychologists in comparison to other professions (e.g., Wright, 2012).

The DCP (2011) and the BPS (2010) documents infer an unrealistic picture of how CMHT professionals may experience engaging in team formulation. In particular, these policy documents do not consider the challenges of working

⁹ Includes specialist CMHTs e.g., Assertive Outreach and Early intervention for Psychosis.

within CMHTs. Rees, Huby, McDade and McKenchie (2004) identified that clinical psychologists felt unconfident and unclear about their role within CMHTs. They identified that clinical psychologists aimed to protect their professional identity. Fears of maintaining professional boundaries are not isolated to clinical psychologists within CMHTs. Brown, Crawford and Darangkamas (2000) and Rees et al. (2004) found that other CMHT professionals including community psychiatric nurses were threatened by role blurring and aimed to maintain status quo. Rees et al. (2004) and Brown et al. (2000) found that other professionals maintained their professional boundaries by resisting undertaking tasks that they believed were inconsistent with their role. Rees et al. (2004) and Onyett et al. (1995, 1997) found that other factors that impacted on consolidating new practice, included limited resources or poor managerial support, limited understanding of the purpose of the practice and attempts to meet bureaucratic goals. These challenges are not discussed within policy documents such as the DCP (2011) to enable better preparation of engaging in team formulation.

Theoretical explanation regarding challenges of integrating new practice in CMHTs.

Challenges experienced in CMHTs when implementing new practice have not generally been explained using a theoretical framework. The psychological construct regarding (team) mental models introduced by Cannon-Bowers and Salas (1990) and applied within business and educational literature can assist in interpreting these findings.

Team mental models are defined as team members' understanding or knowledge structures regarding the team's task or situation (e.g., Cannon-Bowers & Salas, 2001; Klimoski & Mohammed, 1994).

As team mental models constitute knowledge held by team members, this construct may have common elements to psychological constructs such as

'core beliefs'¹⁰ outlined within cognitive behavioural therapy (e.g., Westbrook, Kennerly & Kirk, 2011). However, team mental models are different to 'core beliefs' because of two fundamental aspects, i.e., the origins of the knowledge and the function of the construct.

The first distinction is that team mental models constitute knowledge held by team members, distributed and shared by others. Whereas 'a core belief' is knowledge held by an individual following his/her own idiosyncratic experiences, which may include childhood experiences.

The second difference is that although both 'core beliefs' and team mental models may drive an individual's performance, team mental models are primarily focused on a team's task performance and a goal. The theory of team mental models implies the amalgamation of the knowledge held by a number of team members can have subsequent influence on the team's effectiveness and performance. However, this is not expected from core beliefs.

Mental models can be categorised as a (1) task work mental model which considers the resources and process required to perform a task and (2) a team work mental model which considers the team's tasks, team members' roles, responsibilities, expectations, strengths and abilities (e.g., Cannon-Bowers & Salas, 2001; Klimoski & Mohammed, 1994). For example, during a football match, it is expected that each team member will have a role in this such as a striker or defender. Based on the information distributed within the team, each member would have expectations of how another team member may perform, their strengths, abilities and how all these factors would enable them to meet a shared goal e.g., score a goal in their opponent's net. Similar and shared team and task work mental models may enable the team to meet their shared goal. When teams share task work and team work mental models, this assists in coordinating their activities particularly as this knowledge can assist team members to explain and predict behaviour of others and themselves,

¹⁰ Westbrook et al. (2011) define core beliefs as the fundamental beliefs that an individual holds about themselves, other people and the world in general.

subsequently enhancing task performance (Cannon-Bowers & Salas, 2001; Klimoski & Mohammed, 1994; Lim & Klein, 2006; Mohammed & Dumville, 2001). Shared mental models enable team members to arrive at compatible interpretations of the task resulting in effective working (Cannon-Bowers & Salas, 2001).

Mental models function effectively when the team holds similar, compatible and common knowledge (Mathieu, Heffner, Goodwin, Salas & Cannon-Bowers, 2000). Levesque, Wilson and Wholey (2001) have found that less agreement in mental models was a result of team members not communicating with each other and their managers (Cannon-Bowers & Salas, 2001; Levesque, Wilson, & Wholey, 2001). Communication amongst team members and their managers is important in obtaining similar and compatible knowledge for these mental models (Lim & Klein, 2006; Mathieu et al., 2000). Although observational studies have been used to understand mental models, it is acknowledged that it may not have been possible to isolate mental models from contributory factors, as would experimental methods (e.g., Levesque et al., 2001; Mathieu et al., 2000). However, it is possible to draw from this construct that dissimilar mental models amongst CMHT members and their managers may lead to challenges when integrating new practice. The fundamental issue could be teams lacking sufficient information regarding their task work and team work mental models because of poor communication (e.g., Hannigan, 1999).

The benefits of thinking about mental models in relation to formulation and formulation as a process are two-fold. Firstly, this thinking enables us to understand the influence of team members' knowledge regarding team formulation on the effectiveness of the process. Therefore, this theory holds explanatory power to diagnose a team's ineffectiveness by analysing the team's mental models (Mathieu et al., 2000). Secondly, the theory enables predictions regarding the likelihood of a team's effectiveness based on the compatibility or similarity of team mental models (Hannigan, 1999). This may then help us to think of ways of building similar and compatible mental models to enable an effective team.

The theory of mental models might suggest that introducing team formulation may not be straightforward, as its supposed benefits could be threatened by inadequacies of knowledge held by staff members or lack of communication between professionals and their managers.

Due to the paucity of research in team formulation, it is not known how CMHT professionals experience and perceive engaging in this process. The helpful or unhelpful aspects of team formulation, the processes that may enable the un/helpfulness aspects of this process and the impact of engaging in this process on their clinical practice are not known.

Research Aim and Questions

This study aimed to address the paucity of research evidence relating to CMHT members' perceptions of team formulation. Most of the articles on team formulation present with significant methodological flaws and neglect the potential challenges that may be experienced in MDTs within CMHTs. The present study aimed to answer the following research questions, namely (1) what are considered helpful or unhelpful aspects of team formulation by CMHT professionals, (2) what are the processes or mechanisms (factors) that lead to unhelpful or helpful aspects of team formulation, (3) what is the impact of team formulation on professionals' clinical practice and (4) what are the factors that may influence these outcomes. These questions were left open with no prior criteria so not to limit data collection and analysis. The journal paper addressed research questions (1) and (4) in relation to the outcomes/ products of team formulation. This paper will address research questions (1), (2) and (3), focusing on participants' perceptions regarding engaging in the process of team formulation, specifically the meeting.

EXTENDED METHODOLOGY

This section expands on the journal article by providing a (1) rationale for the methodology chosen with its limitations, (2) discussion of the epistemological underpinnings of the current study, (3) description of the research procedure,

(4) rationale for the use of Thematic Analysis (TA) and (5) the researcher's statement of perspective.

Research Design

Rationale for qualitative methodology.

A qualitative approach was used to capture the depth and complexity of participants' perceptions in this research. This was chosen as qualitative approaches are considered suitable when exploring and understanding participants' experiences of an under-researched phenomenon (Barker, Pistrang, & Elliot, 2002; Braun & Clarke, 2013). Furthermore, qualitative approaches have been reported to lead to rich descriptions of participants' experiences. Particularly, as quantitative methods can limit topics that participants can expand on (Braun & Clarke, 2013; Elliot, Fischer, & Rennie, 1999; Willig, 2008).

Ontology and epistemology.

The framework for qualitative research relies on the ontological and epistemological positions of the researcher (Barker et al., 2002; Braun & Clarke, 2013). These positions influence the methodology frameworks used and the type of knowledge generated (Barker et al., 2002; Braun & Clarke, 2013).

Ontology, the study of the nature of reality, can be understood in a continuum ranging from where reality is assumed to be entirely dependent on human ways of knowing, known as realism, to dependent on human interpretation and knowledge, known as relativism (e.g., Braun & Clarke, 2013). Realism assumes that 'truth' can be accessed by applying research technique, whereas relativism argues that there are multiple constructed realities and what is 'real' or 'true' differs across time and context (e.g., Madill, Jordan, & Shirley, 2000). Between these two positions sits the critical realist position which argues that there is a 'real and knowable' world which can be accessed within subjective and socially located knowledge (e.g., Braun & Clarke, 2013; Madill et al., 2000; Patomäki &

Wight, 2000). This is the ontological position which I¹¹ adopted for this study [see Extended paper: Researcher's Epistemological and Ontological Position].

Epistemology is concerned with the nature of knowledge and addresses the question of what is possible to know (Braun & Clarke, 2013). It is similar to ontology in that epistemological positions have a realism-relativism continuum. The distinction between epistemological positions is whether we think reality can be discovered or created through the process of research. Similarly to the ontological stances, a realist epistemological stance assumes the 'truth' is accessible, whereas a relativist epistemological stance assumes knowledge is based upon perceptions and therefore no single absolute truth can be found (Madill et al., 2000). This continuum has many variants, however, a brief outline of three epistemological stances discussed in psychology will be explored, namely; positivism, constructionism and contextualism (Braun & Clarke, 2013).

Positivism assumes a direct relationship between the world and our understanding. This claims that truth can be discovered using appropriate application of scientific measures. Post-positivism is argued to be a less pure version of the positivist position. This assumes that truth is accessible but researchers are influenced by their contexts which in turn influences the research. Therefore, researchers aim to seek the truth by controlling or removing their subjective influences, as much as they are able to (e.g., Braun & Clarke, 2013). Constructionism argues that what we know is not a true reflection of the world but rather a construction of this based on discourses and various meanings we adopt. Finally, contextualism is argued to be akin to critical realism, assuming knowledge emerges from contexts and that findings are provisional within the situated context (Madill et al., 2000). This position argues that there are various ways of accessing knowledge, which can be true within the context (Braun & Clarke, 2013). Furthermore, this is the epistemological position which I adopted for this study [see Extended paper: Researcher's Epistemological and Ontological Position].

¹¹ TB- primary researcher

Researcher's epistemological and ontological position.

The present study was conducted from a contextualist, critical realist position. This position is committed to an ontological realist position where a differentiated, structured, layered reality exists and an epistemological contextualist position whereby knowledge emerges from situated contexts (e.g., McEvoy & Richards, 2003; Patomäki & Wight, 2000). This perspective assumes that there is a real world but there can be no a priori assumption that scientific endeavour could come to fully reflect this (e.g., Patomäki & Wight, 2000). It is acknowledged that participants' perceptions would be influenced by their own experiences and the extent to which the broader social context impinges on their meanings. It is expected that participants' responses will present something of reality, but this will not be viewed as direct mirroring due to the influence of their social contexts (e.g., McEvoy & Richards, 2003).

Methodology considerations.

Given that a qualitative design was deemed appropriate for the present study, consideration regarding the most appropriate means to collect data was required. My epistemological stance was important to consider to ensure that the data collection techniques were in line with this. In this section a critical evaluation of methods is presented, justifying the most appropriate methods selected for the present study.

Focus groups and rationale.

In this research focus groups were used to gather professionals' perceptions. This meant data could be gathered from the discussions held amongst the participants. As interaction is among participants, there is a reduced level of control from the moderator allowing the prominence of participants' opinions and unanticipated issues to emerge (Kitzinger, 1995). Therefore focus groups assist in capturing concepts with differing levels of consensus and divergence, as discussions held within the group can be contradicted or confirmed by others (Gibbs, 1997; Kitzinger, 1995; Webb & Kerven, 2001). Group interaction on a

topic determined by the researcher is the unique aspect of focus groups compared to other data collection methods (Morgan, 1996; Morgan & Krueger, 1993). It is argued that group membership and cohesiveness assists in supporting and empowering participants to make contributions that they may not feel confident to present on an individual basis (e.g., MacLafferty, 2004; Peterson-Sweeney, 2005; Robinson, 1999). This method of data collection was selected to support participants to openly report their perceptions of team formulation.

Limitations of focus groups.

The methods literature reports that focus groups pose a number of methodological hazards. Each of these weaknesses is considered in turn, followed by an account of how the research sought to limit the impact of these weaknesses.

Focus groups utilise group interaction as part of the data collection method, therefore, people are encouraged to talk amongst each other rather than respond to researchers' questions (Gibbs, 1997; Kitzinger, 1995). However this unique aspect of this method could be problematic for researchers. Researchers have reported lacking control of the data being generated during these contexts (e.g., MacLafferty, 2004). Therefore in this study I ensured that there was a topic list shared with participants prior to the focus groups to assist in orientating participants to the topic (see Appendix C: Topic List). This topic list was also used as participants had agreed to meet for a fixed period of time and this could assist in using this time effectively. Furthermore, it was considered that group dynamics could limit disclosure of information and participants may be reluctant to openly discuss their views (Kitzinger, 1995; Morgan, 1996). This may increase chances of social loafing resulting in decreased participation due to dominant personalities within the group (Gibbs, 1997; Robinson, 1999). In order to manage this, I outlined to the participants that their views were important and any contribution was to be respected, whether it confirmed or contradicted other participants. In situations where participants were quiet, I requested their contributions to ensure that their views

were also heard. Despite this, participants' contributions may be influenced, if not constrained by the group situation. This may lead to the suppression of a wide range of views and attitudes creating a false sense or impression of conformity amongst the professionals (Robinson, 1999). Although this issue may not have been fully resolved in the context of this study, I considered this when conducting the focus groups and analysing the data. With regards to the membership of the group, it was considered that the presence of psychologists during the focus groups may discourage professionals' expressing their views of team formulation; therefore psychologists were invited to individual interviews.

Individual interviews and rationale.

Psychologists who participated in team formulation were not invited to the focus groups as it was presumed that their participation may influence their colleagues' responses. This was considered as literature indicates that psychologists had a facilitative role during team formulation (e.g., Lake, 2008a). Therefore it was decided that individual interviews could assist in managing potential dynamics between psychologists and their colleagues, whilst also ensuring that their perceptions were gathered. Interviews are the most commonly used method in qualitative research (e.g., Frith & Gleeson, 2012) and their popularity is due to their flexibility to be conducted from different epistemological stances (Frith & Gleeson, 2012). Qualitative interviews involve an interviewer questioning and probing a participant to encourage them to talk freely and extensively about a specific topic. This is different to the low moderator style utilised in the focus groups. A semi-structured interview approach was used in these interviews. Probing questions were used so that psychologists could expand on their responses in a detailed manner. This method was expected to provide rich and detailed data relating to team formulation.

Limitations of individual interviews.

Individual interviews can be demanding for researchers, as interviewers steer the interview by questioning participants to expand on particular aspects. It is

therefore argued that individual interviews have the potential to create power imbalances, particularly when the interview may appear controlled by the interviewer (Frith & Gleeson, 2012). It is acknowledged that the interviewer's role can disrupt the shared experience of the interview rather than an inherent aspect of the interview method itself (Braun & Clarke, 2013). In the present study I attempted to maintain a balance between maintaining control of the interview and openly discussing the topic under investigation by sharing a topic list with the psychologists to orientate them to the topic.

Rationale for combined methods.

In this research focus groups and interviews were combined in order to manage the potential dynamics between psychologists and other professionals. Psychologists were invited to individual interviews rather than focus groups due to the presumption that they may influence their colleagues' discussions. This presumption was based on research findings that report the facilitative role adopted by psychologists during team formulation. Literature indicates that focus groups can be combined with other research methods; with the most pairing being either individual interviews or surveys (Morgan, 1996). The main reason for the combination has been to gather greater depth of data using individual interviews and greater breadth of data using focus groups (Crabtree, Yanoshik, Miller, & O'Connor, 1993). It has been found that combining these two methods can be complementary as this could also enable rich data (Kaplowitz & Hoehn, 2001). The combination of these methods has enabled triangulation of data to occur as perspectives on team formulation were gathered from a number of professionals. Furthermore, the combination of these methods is consistent with the critical realist epistemology adopted in this research. Therefore, there was no philosophical or methodological reason why data from these two data collection methods could not be combined and synthesized.

Procedure

Composition.

CMHT members who attended team formulation were targeted for this study. Attendees participated in this study if they gave consent to discuss their experiences in a focus group, whereas psychologists participated following consent being gained to participate in an individual interview.

Focus groups and interviews.

Pre-existing groups

The focus groups comprised of attendees who had ongoing working relationships. MacLafferty (2004) found that participants may be comfortable sharing their thoughts and ideas with others who they know, thus facilitating spontaneity and openness. Furthermore, it was felt that colleagues would be able to relate to each other's comments to experiences in their shared working lives. Kitzinger (1995) argues that pre-existing groups may enable the researcher to tap into fragments of 'naturally occurring' data, as participants may feel comfortable to agree, contradict and challenge each other. However, it is acknowledged that the focus groups were artificially set up for the purpose of this study; therefore it would be inaccurate to assume that these groups reflected everyday interactions. The focus groups were developed and used to encourage professionals to engage with each other and to "draw out the cognitive structures which may not have been previously articulated" (Kitzinger, 1994, p. 106).

Group size

Following the decision not to include psychologists in the focus groups and due to unforeseeable situations in which participants did not arrive to the focus groups due to other demands; I undertook focus groups with three participants. As indicated, focus group research has been found to use three participants

(e.g., Pugsley, 1996), although no consensus has been reached on what group size is most appropriate (MacLafferty, 2004; Morgan, 1996). Studies have reported that sample sizes can range from three to 20 (Barbour & Kitzinger, 1999; Bloor, Frankland, Thomas, & Robson, 2001; MacLafferty, 2004), however, the optimum size for discussion has been reported to be between six and eight participants (e.g., Bloor et al., 2001; Robinson, 1999). Focus group researchers report that the use of smaller groups may lead to high levels of participation and engagement (Krueger & Casey, 2000; Morgan, 1996). In this study it was believed that a focus group of three participants was small enough to allow each participant enough time to express their views and experiences, yet large enough to allow participants to interact with one another.

Number of focus groups

This research undertook three focus groups as this is in keeping with other focus group texts (e.g., Kreuger, 1994; MacLafferty, 2004). It has also been found that following the third focus group, new insights are seldom introduced (e.g., Kitzinger, 1995; Morgan, 1996). The variation between three and five focus groups would depend on factors such as the group composition, resources available and level of structure (i.e., the more diverse the group, the more open ended the questions, the greater the number of groups required) (e.g., Kitzinger, 1995; Morgan, 1996). In this study, three focus groups were conducted and considered sufficient given the homogenous nature of the sample and relatively focused phenomenon being discussed.

Number of interviews

Psychologists from the teams where the focus groups were recruited participated in individual interviews. As research shows that psychologists played an important role in facilitating these meetings, the researcher aimed to manage potential dynamics by inviting them to a separate meeting from their colleagues. It could be argued that three individual interviews is a restricted sample and therefore may not provide the breadth of information. However, the present study acknowledges the participation of psychologists in the individual

interviews as another way of including their views, particularly within the contexts of the focus group participants. This was not intended to be standalone data but rather aimed at triangulating the data gathered from the focus groups. Furthermore, the use of data collection techniques in this manner has been found to be congruent with the critical realist epistemological stance adopted by this research (Frith & Gleeson, 2012).

Sampling and recruitment.

A convenience sampling method was undertaken which involved recruiting participants who met the requirements of the study. The study did not use segmentation aimed at capturing a variety or specific types of participants, as this was not essential in relation to the research questions. Therefore, mental health professionals were recruited from three sites within the British National Health Service (NHS). Initially, the psychologist in each team was contacted via email and telephone regarding the purpose of the study, participation required from their colleagues and the data collection process (see Appendix F: Clinical Psychologists' Information Sheet). If required the psychologist then discussed the feasibility of the data recruitment with their lead professional. If interest and approval for the team to be involved in the study was outlined and following gaining ethical approval from the University of Lincoln and the Research and Development departments of two NHS trusts, the psychologist was requested to distribute the information sheets, informed consent forms and the demographic form to their colleagues, via email requesting responses to be sent directly to me (see Appendix D & G: Focus group participants' Information Sheet and Demographic Information Form; Appendix H: Consent Form). Staff members were able to contact me for further information about the study. A date and venue for the focus group was arranged following confirmation to participate in the study. Participants were sent a reminder of this to ascertain their availability. Following the focus group, an individual interview was undertaken with the psychologist at a time and place convenient to them. Likewise, consent was gained prior to this and understanding of this was ensured. This sampling method is not without fault, particularly as it raises questions relating to the

generalisability of the findings and the representativeness of the sample [see Extended Discussion: Strengths and Limitations of the current study].

The sessions.

The focus groups took place between April and July 2014 and the interviews occurred in July 2014. I was the moderator for the focus groups and interviewer for individual interviews. In this section a description of the data collection process will be outlined.

On the day of either the focus group or interview, participants began by reviewing the Participant information sheet, Consent form and the Topic list (see Appendix C: Topic List; Appendix F & G: Clinical Psychologists and Focus group participants' Information Sheet; Appendix H: Consent Form). Participants were given the chance to ask questions prior to written consent being sought. Participants were also given the option to have a summary of the results sent to them, once this had been written up. The contact details of the participants who wanted these results were provided and withheld for this purpose. Demographic and clinical information was collected from participants on the day of the focus group and interviews to understand their context of their experiences (see Appendix D: Clinical Psychologists' and Focus group Participants' Demographic Information). The demographic forms requested staff to outline their age, gender, professions and number of years they had been working in the NHS. Further questions regarding participants' attendance of team formulation and training on psychological theories and team formulation was requested. Participants also consented to be audio-recorded using a digital dictation device. Specifically prior to the focus group, ground rules were then established, including the importance of maintaining confidentiality by not revealing personally identifiable information about other participants. When recording of the focus group or interviews was completed, participants were reminded of their right to withdraw from the study within 24 hours. I did not receive any contact within 24 hours following the recording, therefore transcription commenced.

Semi-structured interview schedule and topic list.

A semi-structured interview guide was used to guide and open up dialogue regarding team formulation (see Appendix B: Schedule of Questions). The questions were used as a guide and beyond this an open and flexible approach was used. During semi-structured interviewing, probing and clarifying questions were used to gather in-depth responses (Krueger, 1994). A topic list was developed using the main themes from the interview guide and this was shared with participants during focus groups and interviews (see Appendix C: Topic List). This enabled me to adopt a 'low' moderator style during the focus groups, supporting participants to be orientated to the topic and this directed the discussion amongst participants (Kitzinger, 1995; Morgan, 1996; Robinson, 1999).

Ethical consideration and approval.

It was important for the researcher to gain ethical approval before commencing data collection. Ethical approval was gained from the University of Lincoln's Ethics Committee on the 16th of September, 2013 (see Appendix I: University of Lincoln Ethical Approval Document); and Research and Development departments of two NHS trusts on the 4th of November 2013 and the 14th of January, 2014 (see Appendix J: R & D Ethical Approval documents). This study followed the guidelines outlined in the Research Governance Framework for Health and Social Care (Department of Health, 2005), BPS code of human research ethics (BPS, 2010b) and Health and Care Professions Council's standards of conduct, performance and ethics document (2012).

A number of ethical dilemmas were considered and dealt with during the research process. It was expected that participants may attend the focus groups or interviews during work hours which would impact on their time. Participants were not compensated for their time; however, data collection was arranged at the most convenient time for them. In order to ensure that participants were fully informed, Participant information sheet were provided (see Appendix F & G: Clinical Psychologists' and Focus Groups Participants' Information Sheets).

These were sent via email and the information sheet was further reviewed prior to the beginning of the focus groups and interviews. Participants had an opportunity to clarify any concerns they had regarding the study, before signing and dating the consent form (see Appendix H: Consent Form). Participants were informed that they could withdraw their data 24 hours following the recording of the focus group. The information sheet highlighted that after this time period participants could not withdraw their information. All data was kept and transported securely (in a lockable bag) in accordance with the Data Protection Act (1998). During transcription, electronic data was stored on an encrypted password protected memory stick. The confidentiality of participants was ensured by using participant identification numbers in replacement of names and all other identifiable information was omitted. Furthermore, I ensured that each party had confidence that what was discussed during data collection was not then discussed in the subsequent setting. This was stated in the informed consent form to ensure the study did not disrupt participants' working relationships. Participants were also given the opportunity to receive a summary of the research findings once these were written up. Their contact details were securely stored until a summary of the research findings were sent to them, after which they were destroyed.

Data Analysis

Different methods and rationale for TA.

Qualitative approaches lend themselves to a range of data collection and analysis methods, however, researchers' epistemological and theoretical frameworks may influence what is chosen (Harper, 2012). This section will outline the alternative methods of analysis that were evaluated before deciding that Thematic Analysis (TA) would be most appropriate. A brief evaluation of the alternative data analysis methods, namely Interpretative Phenomenological Analysis (IPA), Grounded Theory (GT) and Discourse Analysis (DA) will be introduced.

TA procedures have been reported to be used in other qualitative procedures. However TA has also been recently recognised as a distinct method in its own right (Braun & Clarke, 2006; Willig, 2013). It is defined as “a method for identifying, analysing and reporting patterns (themes) within data” (Braun & Clarke, 2006, p. 79). TA offers a flexible approach to data analysis and requires researchers to make decisions regarding their process of analysis. Themes can be either be identified from an inductive (bottom-up) approach where they are strongly linked to the data or from a theoretical (top-down) approach whereby analysis is theoretically driven (Braun & Clarke, 2013). The saliency of a theme is not determined by its frequency within the data set but rather the extent to which it answers the question (Braun & Clarke, 2006). TA outlines that themes can be analysed at the semantic level whereby explicit and surface meaning of the data is gathered or latent level whereby underlying ideas, assumptions or conceptualisations are analysed. It can offer a rich description of the data set or an in depth account of one aspect of the data, however it is suggested that an account of the entire data set is useful when using this approach in an under-researched area (Braun & Clarke, 2006). Amongst the benefits described in this section, TA was also chosen as it could be used to analyse and synthesize large quantities of qualitative data and afforded considerable flexibility in the application of this method.

IPA has particular interest in how people make sense of their experiences (Larkin & Thompson, 2012). This method of analysis aims to capture and reflect upon the principal claims and concerns of participants and also offer an interpretation of this material (Larkin & Thompson, 2012). IPA is concerned with meaning and processes rather than with events and their causes. It argues that researchers are unable to directly access participants' world and hence a dual interpretative process is used known as double hermeneutic. In comparison to TA it was felt that IPA interprets “too far” beyond what is required for this study, as it aims to outline what participants mean rather than what they are saying. The present study had limited literature on team formulation and it was important to capture participants' perceptions by staying close to the data using both semantic and latent level of analysis used in TA. The inductive nature of this analysis meant that my interpretations played less of a central role as the

data was constantly referred to. Whilst TA shares some similarities with IPA in that they both focus on subjective human experience, it was felt that TA offers a broader analysis as it can incorporate social and cultural phenomena. Furthermore, it was felt that IPA would not lend itself as easily as TA to the analysis of focus group data and that it would represent too much of a fundamental shift from the idiographic to be considered “true” IPA (Larkin & Thompson, 2012).

GT aims to systemically generate a theory by saturating data (Tweed & Charmaz, 2012; Willig, 2008). GT is argued to be best suited to research questions relating to social processes and how these may influence behaviour, interactions and interpretations (Tweed & Charmaz, 2012). As this research did not intend to build a theory it was not appropriate to use GT. TA appeared to be most appropriate for this study as it could offer a broader understanding of participants’ perceptions on team formulation.

There are a number of strands of Discourse Analysis (DA) and all have an interest in the role of language and the construction of social realities (Willig, 2008). Language and discourse are seen as the means to which a researcher can access participations’ understanding of the world. It was not the aim of this study to focus on the linguistic properties of participants’ reports, therefore DA was not considered the most appropriate means of analysis.

Critique of TA.

Although Braun and Clarke (2006) offer practical and accessible guidelines for conducting TA, they have argued that researchers should flexibly use this framework. Whilst this could be viewed as an advantage, this provides little guidance for the researcher when deciding what aspects to focus on (Braun & Clarke, 2006). This flexibility also means that TA has not developed an ‘identity’ as an analytical method, unlike more ‘branded’ forms of analysis like IPA or DA (Willig, 2013). There are potential pitfalls in this as researchers may present poor analysis if they should mismatch the data and the analytic claims or produce reports with insufficient data interpretation (Braun & Clarke, 2006).

Other criticisms of TA relate to criticisms of qualitative methods as a whole, for example the perception that ‘anything goes’ (Braun & Clarke, 2006). Other disadvantages appear when TA is compared to other qualitative methods. For instance, in contrast to DA, (semantic) TA does not allow the researcher to make claims about language use, or the fine grained functionality of talk. Despite this, it is felt that a rigorous thematic approach can offer insightful analysis, unanticipated insights and can be useful in answering particular research questions.

***A priori* decisions.**

TA was carried out within a contextualist, critical realist stance using the guidance of Braun and Clarke’s (2006). Prior to commencing analysis, *a priori* decisions were made.

Firstly, a decision had to be made regarding how the analysis is approached, either ‘bottom-up’ (inductive) where themes are strongly linked to the data or ‘top-down’ (theoretical) whereby themes are driven by theoretical interest. It is argued that a ‘top-down’ approach is at risk of ignoring the naturalistically occurring themes (Boyatzis, 1998; Willig, 2013). I decided to take an inductive, bottom-up approach as this process enables participants’ experiences to be voiced as accurately as possible, allowing unforeseen themes to emerge and shape the direction of the study. The method of analysis was purely inductive in that I was immersed in the data; however, it is acknowledged that such analyses can never be free from researchers’ theoretical and epistemological commitments (Willig, 2013). However, this should not be seen as a disadvantage as awareness of potential influence on the research could complement understanding. Nevertheless, the epistemological stance adopted in this research argues that it is likely that some truth will be identified within this influence.

Secondly, it was important to consider what counts as a theme. This study utilised the principle that a theme is not necessarily dependent on quantifiable

measures, i.e., its prevalence in the dataset (Braun & Clarke, 2006, 2013). A theme was considered to capture something of importance, that gives meaning to the research question rather than something defined by its occurrence within the data set (Braun & Clarke, 2006; Willig, 2013).

Thirdly, a decision regarding whether to identify themes at the semantic (manifest) and/or latent level was considered. At the semantic level, themes are identified within the explicit or surface meanings of the data which are directly observable in the participants' reports (Willig, 2013). At a latent level of analysis, identification and examination of underlying assumptions and conceptualisations or implicit meanings of the semantic data are introduced (Braun & Clarke, 2006). I decided to utilise a mid range analytical process in which I used both semantic and latent analytical approaches. Willig (2013) argues that neither one nor the other level of analysis would generate satisfactory insights on their own or capture the essence of the data; therefore a combination of the two is required.

The TA procedure

The analysis followed Braun and Clarke's (2006) six phase guide for TA. This guide is expected to be applied flexibly and it was necessary to move back and forth throughout the stages (Fereday & Muir-Cochrane, 2006). Braun and Clarke (2006) describe how the analytical process begins when the data is transcribed, followed by repeatedly reading the data in an 'active' way. I transcribed all six recordings. Transcription included verbatim (an 'orthographic' account) and emotional comments (e.g. laughter) as this could add richness and depth to the data (see Appendix K: Meaning of Transcription Conventions). I spent time checking and becoming familiar with the data. This process of immersion allowed initial ideas, patterns and meanings to be discovered.

The second stage involved systemically going through the transcripts, unit by unit, distinguished when specific points of talk concluded. In the margin of the transcripts, initial codes were jotted down which consisted of descriptive labels of each unit, as well as other interesting words, phrases or concepts (see

Appendix N: Sample Analysis 1 & 2: Focus group data and Individual interview data). My research supervisors were consulted and initial codes were reviewed to assess that I was staying close to the data and clearly reflecting what was in the data.

During the third stage, I began to cluster the initial codes that had been identified across the data set into potential themes (see Appendix L: Initial thematic map; Appendix M: Early stages thematic table). This was done by separating codes into pieces of paper and organising them into theme piles. Particular attention was paid to similarities and differences between the participants' accounts. A 'miscellaneous' theme was also temporarily used for codes that did not seem to fit into the main themes. This process enabled links to be made between codes, themes and different levels of themes (main- and sub-themes).

In the fourth stage, transcripts were revisited to check whether the initial stage of clustering was an accurate representation of the data extracts and of the data set as a whole. Once the themes had been reviewed, a thematic map and subsequently a table were developed to present the themes and their relationships between them. During this process, some candidate themes were broken down into separate themes where the data was too diverse. Where there was considerable overlap, some candidate themes were collapsed into an overall theme. Some themes were discarded completely where there was not enough data to support them. This process resulted in several versions of the thematic table being developed (see Appendix M: Early stages thematic table; see Extended Results section).

In the fifth stage, each theme were refined, defined and given a clear name to capture the 'essence' of what it was about. As the themes were refined, the transcripts were read repeatedly to look for further examples as well as for disconfirming data. Finally in the sixth stage, the themes and data extracts were selected and reported in the write-up, addressing the research questions.

Analysis of focus group data.

Focus group data provides information regarding interaction between members, which may include participants sharing ideas and even debating each other (Duggleby, 2005). Researchers' observation of participants' consensus and divergence of opinions can lead to valuable source of information (Gibbs, 1997; Kitinger, 1995; Webb & Kerven, 2001). Likewise, the interactive feature of focus groups is encouraged to be analysed and reported (Duggleby, 2005). Duggleby (2005) outlined three potential ways for analysing group interaction data including;

- Providing an appropriate description of the group dynamics incorporated in the analysis. These descriptions could relate to groups' adherence to the topic, main topics that evoked conflict or support, common experiences expressed, dominant and silenced opinions. It has been argued that interaction data would not be analysed using the same methodological approach as the rest of the data or integrated with other focus group data. This would therefore risk ignoring and not integrating data with other types of focus group data (Duggleby, 2005);
- Analysing the group interaction data separately using the congruent qualitative methodological approach and then integrating it with the rest of the data. This is likely to risk losing the benefits of integrating the interaction data and the participants' accounts.
- Incorporating the data into transcripts by including interpretations of the group interactions alongside coded verbal data (Morrison-Breedy, Côté-Arsenault, & Feinstein, 2001). Researchers recommend using an audit trail so that group interaction data can be accessed when required (Duggleby, 2005).

For the current study, the latter approach was used. This involved analysing the group interaction data as part of the analysis of the data set. Group interaction was coded in the margins (such as challenging, agreement, defending, reinstating) (see Appendix N: Sample Analysis 1: Focus group data).The

findings were integrated within the themes and used to enrich understanding of convergent and divergent participants' reports.

Establishing Quality

In this research measures were undertaken to ensure credibility and trustworthiness of the findings. This has been a contentious issue in qualitative research and has led to guidelines outlining ways of ensuring this (e.g., Elliott et al., 1999; Flick 2007). These guidelines are not intended to be exhaustive but expected to be used flexibly in conjunction with my epistemological position and the methodology chosen (Barbour, 2001). In the present study, the most commonly used procedures to promote quality in qualitative research were considered and some were utilised including, audit trails, thick and rich description, triangulation, member checking, and researcher reflexivity (Carlson, 2010; Elliott et al., 1999; Flick, 2007). A description of these procedures is provided below.

Audit trails.

An audit trail is referred to as the maintenance and careful documentation of all components of the study. In this study I kept documentation relating to the entire research process, including information on the formation of research aim through to the write-up. A research diary was used to record correspondence, focus group notes, initial ideas and interpretations, code and theme development and various drafts of analysis [see Extended Discussion: Critical Reflection]. Furthermore, the results section contains extensive direct quotations from participants' responses which can be used to check the validity of the analysis.

Thick and rich description.

I ensured that a thick description of the research process was reported in this study in order to increase the credibility and trustworthiness of the findings. This involved providing information regarding the research process so others could

follow what had been done. This also included a detailed description of the context and circumstances surrounding the phenomenon, participants' information, data collection and analysis, as suggested by Curtin and Fossey (2007). Thick and rich descriptions have also been believed to be a way of increasing a sense of connection with participants (Carlson, 2010). This study reported participants' details whilst ensuring their confidentiality was maintained (see Appendix E: Participants' Demographic Information).

Triangulation.

Triangulation is defined as methods of extending researchers' activities "far beyond what is normally done" (Flick, 2007, p. 37). This process is aimed at producing in-depth knowledge and promoting quality of research (Barbour, 2001; Yeasmin & Rahman, 2012).

Denzin (1978) proposed four methods of triangulation:

1. Data triangulation (using data collected at different time, location or with people)
2. Investigator triangulation (using several different researchers or analysts);
3. Theory triangulation (using multiple perspectives to interpret data);
4. Method triangulation (using multiple methods to study a single phenomenon).

This study employed data; investigator and method triangulation to ensure the quality of the findings were maintained. Investigator triangulation involved myself and my research supervisors, independently coding transcripts and themes, then cross-checking the credibility of codes and themes. This process also assessed that my perspective on the data could be understood and followed by others. Furthermore, I was able to consider other competing interpretations and explanations before the final version of the themes and subthemes was developed. I also used method and data triangulation by integrating data from the focus groups and individual interviews. The combination of these methods and data collected aimed to produce richness

and depth of knowledge regarding professionals' perceptions of team formulation.

Participant validation.

This process involves the cross checking of research findings with participants (Barbour, 2001; Curtin & Fossey, 2007; Elliot et al., 1999). Although this process results in an opportunity for participants to verify the accuracy and interpretation of the data, this technique was not used due to a number of practical and philosophical reasons. Firstly, participant validation assumes that there is a fixed truth or reality that can be accounted for by a researcher and confirmed by respondents, a position that does not fit with the critical realist epistemology adopted in this study. On a practical level, this would have been difficult to apply to the focus group data as participants may have different views of the same data and their interpretations may have changed since data collection.

Researcher reflexivity.

This involves direct acknowledgement from researchers that they are active participants who have the ability to influence the research process (Curtin & Fossey, 2007). The researcher aims to be explicit in order to ensure that findings are reflective of the participants rather than the researcher's perspectives (Curtin & Fossey, 2007). This study aimed to meet this criterion by stating my position as the researcher [See Researcher's statement of perspective]. In addition to this, I used a research diary to record thoughts, impressions, feelings and decisions, as well as reflections on how my values, beliefs, assumptions and experiences may have influenced the interpretation and presentation of data [see Extended Discussion: Critical Reflection].

Researcher's Statement of Perspective

A researcher's statement of perspective is considered useful to help readers interpret and understand the analysis, orientating them to the research and the

researcher (Elliot et al., 1999). In line with this, I am a trainee clinical psychologist who developed an interest in team formulation at the start of my training. During training there was an emphasis on trainees identifying themselves differently from other professionals, particularly by considering the 'unique contribution' they could offer to other professionals. I found that the BPS and the DCP published documents highlighting that other professionals benefitted from team formulation. Although I came to the research as partial fulfilment of the course requirements, I hoped that this process would broaden my understanding of team formulation. I am aware that my training as a clinical psychologist would influence how I understand team formulation and to manage this effectively, I have utilised my reflective journal and sought supervision, when required.

EXTENDED RESULTS

Two overarching themes were identified in the focus group and interview data (Table 11). This paper focuses on the overarching theme relating to the 'status of team formulation' and presents participants' perceptions regarding engaging in the team formulation meeting. The overarching theme discussed in the journal paper focused on the outcomes of team formulation, specifically how ideas derived from team formulation, integrated into care plans (CPs) were viewed and how professionals' perceptions influenced the utilisation of CPs.

The findings presented in this paper address research questions (1), (2) and (3), namely what are considered helpful or unhelpful aspects of team formulation, what are the processes or mechanisms (factors) that lead to unhelpful or helpful aspects of team formulation and what is the impact of team formulation on professionals' clinical practice. In this section, reference to either 'psychologists' or 'attendees' indicate data distinctively stated by either group and phrases such as 'participants' and 'professionals' identify reports stated by psychologists and attendees. The main- and sub-themes are presented as being distinct from each other to ease reading; however interrelationships between these will be evident.

Table 11

Thematic table presenting perceptions of team formulation in practice

Overarching themes	Main themes	Sub-themes
The status of team formulation	The Position of Team Formulation	<i>“Stepping on a brake”/ Team formulation is not work</i> <i>Priority/ benefits found elsewhere?</i>
	Associated Risk	<i>Safe to be transparent</i> <i>Shared responsibility and decision making</i>
	A “Luxury”?	<i>Broadened understanding</i> <i>Information gathering</i> <i>Exploration of ideas</i> <i>Risk management</i> <i>Validation</i>
Outcomes of team formulation	Significance of Care	<i>Tangible products</i>
	Plans (CPs)	<i>Managing overwhelming ideas</i> <i>A rationale to flexibly test ideas</i>
	Life expectancy of CPs	<i>Different expectations</i> <i>Short- or long- lived CPs</i> <i>Decision makers/ factors</i>
	Perceived value	<i>Hopeful psychologists</i> <i>Waste of time?</i>

The Position of Team Formulation

This main theme identifies the ‘outsider’ and distinct position of team formulation in comparison to attendees’ repertoire of work and other demands. Furthermore, this theme presents conflicting reports from participants regarding the benefits of team formulation, whether these could be accessed elsewhere

and their perceived value. These factors appeared to influence attendees' perceptions regarding engaging in team formulation.

“Stepping on a brake”/ team formulation is not work.

Participants' accounts led to an understanding that attendees' normal repertoire of work was influenced by psychiatry, resulting in a fast-paced and reactive response to crisis management. The impact of team formulation on attendees' way of working was described as “stepping on a fire fighting, reactive brake” requiring attendees to “stop, step back and look at the bigger picture” (Psychologist John; Team B). This ‘braking’ response was reported as conflicting with attendees' repertoire of work, which included moving between tasks with minimal opportunities to stop (see below). As a result of this, psychologists reported experiencing difficulty in justifying team formulation to attendees who perceived ‘work’ as action-oriented.

Psychologist John: the environment has become more chaotic (.) which puts more pressure on community mental health because while I would like to try to help stop people from reeling from one crisis to another (.) the reality is they are being battered by so many demands that means the thinking space is constricted

Psychologist Rose: we had some resistance from the person who used to be in the team who didn't really want to do any of the thinking and wanted to do the doing (.) they wanted to- ‘tell me what to do (.) I'm going out there and doing it (.) I don't want to be sitting here in the team meeting talking about all this stuff (.) going round in circles and what's the point’

Psychologist Rose's report is consistent with a minority of attendees' reports regarding engaging in team formulation. In the above quotation Psychologist Rose reported that the attendee perceived their role as implementing action rather than formulating action plans. The use of the phrase “going round in circles” identifies that team formulation may have been perceived as potentially

unhelpful if it did not influence their work or lead to action. In this quotation the attendee showed reluctance in “sitting and talking”, implying that this may have been perceived as potentially unproductive, therefore, an unhelpful aspect of team formulation. Across all the teams, attendees also reported a number of helpful aspects of this process, which contrast with the above reports (as discussed in the theme relating to the “luxury” of team formulation).

Priority/ benefits found elsewhere?

Throughout the focus groups attendees reported that team formulation was not the main focus of their work; therefore this was given a low priority.

Professionals also reported that they hoped that team formulation could be given a higher priority in their work and they identified that the context in which team formulation was introduced could be modified to support this (Team C below).

Kate: I'd like there to be more (.) emphasis on it and the time afforded for it (.) ... making sure that something was put in place so that it could work

Laura: yeah (.) it's not the formulations concept's fault or actually doing it (.) it's actually being able to contribute 100% each time we do it and I think maybe something needs to be put in place that allows us to be able to do that

One psychologist and attendees from one focus group also reported that the benefits of team formulation could be found elsewhere as presented below.

Martha: there were other members of the team who felt that their formulation was covered in other areas (.) for example CBT supervision (.) one to one supervision with the psychologist (.) so therefore they didn't feel this was the most appropriate use of time
Team B

In line with the above extract, attendees in team B reported that they did not feel they were “losing out” if they did not engage in team formulation. In contrast to this, most participants reported that team formulation provided extra benefits that could not be accessed in any other aspect of their work (explored in the theme relating to the “luxury” of team formulation). As a result of these benefits participants also reported hoping to maintain their engagement in team formulation (as illustrated below).

Sally: I think shared formulation has been useful on the two occasions I have seen it (.) and it is something that I will keep pushing forward in the team (.) with the people who want to engage in the process ((*laughter*))
Team B

The above extract is consistent with reports from participants who aimed to continue engaging in team formulation as they found it both a helpful and useful process. In the above extract Sally explained that she would continue “pushing this forward” with people who wanted to engage in the process. There was a consistent pattern of reports regarding this, across all teams, which suggested that engaging in the process was optional and was done so by those who perceived a value in the process.

The main theme regarding the ‘position of team formulation’ identifies that team formulation impacted on attendees’ practice by ‘braking’, which conflicted with their fast paced way of working, influenced by psychiatry. This difference to their normal way of working was described by psychologists as resulting in difficulty in justifying team formulation to attendees, who often perceived it as a low priority. A minority of attendees reported that team formulation was unhelpful if it did not (1) influence their work, (2) lead to action and (3) the “sitting around” could be perceived as unproductive. Across participants’ reports, there were conflicting reports regarding the benefits of team formulation being accessed elsewhere. This could be seen as a potential factor influencing participants’ engagement in the process. Furthermore, attendees identified that engaging in team formulation was optional and was engaged by those who valued the

process. These may have been other factors that may have influenced engaging in this process.

Associated Risk

This main theme presents participants' reports regarding team formulation being associated with risk as it could potentially threaten their job security. A safe environment was reported by participants across the teams as helpful in enabling attendees to engage in the process whilst feeling reassured that the security of their jobs was not threatened. This theme also identifies the role of psychologists and team leaders' support in developing a safe environment in team formulation. This theme also presents a consistent pattern of participants' reports regarding the function of team formulation as supporting shared responsibility and decision making. This function was also reported to be helpful in securing attendees' jobs.

Safe to be transparent.

Participants across all three teams reported anxieties regarding being open about clients' difficulties (as illustrated below).

Martha: = team formulation takes you out of your comfort zone
doesn't it

Craig: =yeah

Sally: I think people feel quite exposed (.) if I think about the
people in my team that are not so keen on it there are the people who
struggle to be quite open about what they are doing and what they are
not doing

Psychologist John highlights that this "transparency" can be perceived as failing or being incompetent.

Psychologist John: the simple factor of a formulation meeting is somebody saying (.) 'I am having trouble with this' (.) and by it's very nature it's got to be transparent and people can struggle with that (.) that can feel scary particularly if you have got performance targets all the time (.) and you are already feeling like you are failing and not being good enough

Across two of the focus groups, attendees reported that it was important for team formulation to be a safe environment, where they would not be criticised or deemed incompetent for discussing their difficulties with specific clients. Attendees also reported that when team formulation was perceived as safe, this was helpful in enabling them to receive support from other professionals regarding their challenging clinical work. This suggests that a safe environment therefore alleviated attendees' anxieties regarding the security of their jobs, enabling them to make use of this process to gain support.

As identified in the below extract and across all three transcripts, psychologists reported believing it was their responsibility to build a safe environment for attendees.

Psychologist John: as a psychologist you've got to try to build a team system where they can own that and not feel like they are (.) weak for it and then you have to do a lot of validation and say (.) 'no no I can understand why you are struggling it's a really tricky case (.) I think anybody would be struggling' (.) ((*laughter*)) you have to do that to get people to calm down and go 'ok (.) I can talk about this (.) it's the norm to be struggling with this yes yes yes' (.) then they can own it (.) then that's not from the position of weakness (.) it's actually from the position of erm (.) validation (.)

Psychologists reported spending a vast amount of time validating attendees' experiences to maintain engagement in team formulation. Psychologists also reported that validating attendees' experiences was a helpful and important aspect in the development of team formulation. The psychologists' efforts in this also suggests that team formulation is different from other professionals'

practice and that it could be something that other professionals would need to be accustomed to (as identified above). The theme relating to the 'position of team formulation' presents consistent reports from attendees across the three teams who felt that team formulation was different to their normal way of working.

In addition to this, psychologists and attendees reported that team formulation was a safe environment when this process received support from their team leaders. Participants reported that this support reassured them that they were "doing the right thing", suggesting that professionals may have been worried about being criticised (e.g., Psychologist Rose). Professionals also reported that the support of the team leader also "enforced" their attendance to these meetings which also alleviated their anxieties regarding engaging in team formulation (Psychologist John). Participants reported this support of the team leader enabled them to engage in team formulation and was integral in the initial development of this process.

Sharing responsibility and decision making

Participants across two teams reported that team formulation helped in sharing decisions and responsibility of clients, as decisions were justified and discussed with the team.

Psychologist Thomas: everybody had a responsibility for it so it made you feel supportive for people carrying a difficult case because if it went wrong and there was an inquiry (.) you know it was the fact that it had all been discussed in a team and the fact that there was a formulation people had back up that they were not alone ...we have all discussed it (.) which is both in terms of people having that (.) well in the crudest terms that they have covered their back in terms that it has been discussed and it has been written down

Lisa: it supported the team to engage in positive risk taking because you knew that what you were about to engage in with the person had

risks attached to it (.) but it felt as though you were doing that with support of the team and worst case scenario it felt as though you would be able to defend your action

Team A

The extracts above identify the potential function of team formulation as an opportunity to share responsibility for difficult clients with other attendees. Consistent accounts were reported by other participants who also stated the benefits of shared decision making and the diffusion of responsibility. Some of the psychologists reported that team formulation was often accepted by team leaders as a measure to manage decision-making for difficult and risky clients. This was also reported in the previous extract as the participant discussed how such decision making could then be utilised if there was an inquiry. The phrases “covering your back” and the ability to “defend your action” in the above extracts suggest that the function of sharing responsibility and decision making ensured attendees could not be blamed or criticised about the decisions made. In conjunction with this, participants across the teams reported that this process also reassured them of the security of their jobs.

This main theme regarding the ‘associated risks’ of team formulation presents attendees’ reports that team formulation was helpful when it was a safe environment and a setting to share responsibility and decision-making. These settings were said to be helpful because they ensured that attendees did not feel criticised regarding their competence or their decisions, therefore enhancing job security. Attendees also reported that when they felt safe in team formulation this provided them with an opportunity to receive support from their colleagues, which they found a helpful aspect of the process. The support of team leaders was reported by participants across the teams as an important factor in creating a safe environment and supporting shared responsibility and decision making. Psychologists also reported validating attendees’ experiences as a helpful process, both in supporting attendees to deal with the exposure of discussing their difficulties and in the development of team formulation. Attendees across all teams reported positive experiences of being validated for their difficult experiences with their clients, as discussed in the following theme.

A “Luxury”?

Psychologist John: they don't see that as work (.) they see that as a nice time with their colleagues (.) what they see as work is being out there with the service users (.) not being in thinking about the most appropriate care for the service users ((*laughter*)) (.) they see it as a luxury (.) in that way that it is a nice thing to do (.) now whoever said that work shouldn't be nice (.) but that is their experience of most case managers (.) it's stress (.) it is clawing their way through their caseloads (.) never feeling like they are on top of anything so (.) having a time when they are away from them they feel guilty ... they can't justify it to themselves

David: when people are all fed up in this trust right now (.) the extras about doing formulation meetings get missed really because we are all concentrating on just surviving getting through the day (.) [it's an extra]

Lisa: [yeah that's true] it's like a luxury

Team A

The above extracts are consistent with reports from attendees who perceived team formulation as a “luxury” because it led to a pleasant experience with their colleagues. Attendees reported that team formulation was considered separate from ‘work’. This implies that pleasantness and work could not be simultaneously experienced in their repertoire of ‘work’, particularly as ‘work’ was often experienced as strenuous and demanding. Furthermore, participants also reported that attendees were overwhelmed by their work demands and found it difficult to justify engaging in team formulation. Psychologists and attendees both reported that attendees felt guilty when they engaged in team formulation because they considered that this prevented them from undertaking their work. Across all transcripts, participants defined team formulation as a “luxury”: a process that was (1) not considered as attendees' normal way of working or part of 'work', (2) pleasant and (3) prevented meeting the demands of their work. This theme is similar to the theme relating to the ‘position of team formulation’, which identifies team formulation as being distinct from attendees’

normal way of working, but is dissimilar because it provides an understanding of attendees' perceptions of this difference to their normal practice as something that predominately led to helpful and valued aspects of team formulation. In this theme five 'luxuries' were identified in attendees' accounts.

Broadened understanding.

Participants reported that the involvement of other professionals in team formulation was important in broadening understanding of clients' and attendees' experiences. Participants reported that other professionals' contributions helped them feel less "stuck" in their clinical work (e.g., Team B).

Most attendees reported that team formulation helped them understand clients' presentations from a different perspective. As a result of an alternative perspective described as a "fresh focus", attendees reported their ability to work with their clients (e.g., Team A). Attendees also reported that this process was helpful as it enabled a shared understanding of clients because of the involvement of other professionals. It was suggested that this broadened understanding of clients' presentations led to a new understanding and enabled attendees to work effectively with their clients.

In contrast to this, a minority of attendees stated that understanding clients' presentations from a different perspective was potentially threatening for other professionals. Attendees reported that challenging other professionals' perspectives was potentially difficult for those who felt insecure or uncomfortable with change. This suggests that professionals' resilience in this process may influence perceptions regarding the helpfulness of alternative perspectives.

Attendees reported the benefits of a range of professional contributions, whereas the three psychologists focused on their own psychological contributions. This suggests that psychologists and attendees may have different perceptions of what they consider helpful contributions. Psychologists reported that their understanding of team formulation was related to

understanding clients' presenting problems from a psychological perspective; therefore psychological contributions would be important and helpful in this process.

Most attendees also reported that team formulation helped them understand their own emotions towards clients. This broadened understanding of their emotional processes was reported to lead to positive changes within the staff-client relationship.

Laura: ...I've noticed quite a lot that it tends to point out quite (.) significantly how we tend to start mirroring our clients' actions in some ways...if a client is quite uptight or quite sort of stressed and anxious about a certain thing you know (.) we can find ourselves feeling that way but not necessarily about the same things as the client is when (.) they're anxious because x y and z's happened to them (.) and we're sometimes anxious and that about how we're going support them to best deal with x y and z so we're sort of mirroring their feelings... (.) we try to understand and unpick the frustrations we're having in order to understand how the client's feeling in order to work out a plan of how to move that forward (.) so obviously the client's not feeling frustrated we're not feeling frustrated with the client and (.) and things start to move again

Team C

Across all focus groups attendees described and agreed with each other that the process of analysing their emotions led to an understanding of clients' emotions. Attendees reported that this understanding led to a plan on how to work with clients, which made them feel less 'stuck' with their clinical work. Furthermore, attendees reported that understanding their emotions resulted in positive changes in their emotions and this helped them to feel less frustrated. As emotions "mirrored" those of their clients, this then led to positive staff-client relationships and enabled attendees to work effectively with their clients (as illustrated in the previous extract).

Information gathering.

Attendees reported that gathering information from other professionals was a “luxury”, as this was different from their normal repertoire of work. They reported that other professionals' contributions were useful and helpful only if the information was relevant to their clinical work. Attendees also reported that gathering information on clients' past experiences assisted in understanding the development and maintenance of clients' difficulties and also provided an opportunity to re-examine past interventions. This was reported to offer a way of working effectively with their clients.

In all focus groups, attendees agreed with each other that comprehensive information had to be gathered in team formulation. This contrasted with the psychologists' reports regarding their attempts to support their colleagues to use limited information during team formulation. Attendees reported feeling anxious about using limited information as they felt they could not make certain predictions.

Psychologist Thomas: sometimes we get clinicians who feel they have to know everything about their client and if they don't they are somehow failing

Psychologist Rose: because of some of the staff anxieties they think 'we haven't got everything' and say (.) 'how can you kind of speculate what the impact is when you don't know for sure'

Craig: = I think by that (a proper formulation) I meant a more depth knowledge history- better history (.) and to some degree (.) knowing the person and not just knowing about them (.) having some degree of relationship whereby one can quite accurately predict outcomes of things

Team B

As indicated in the above extract, Craig stated that comprehensive information led to a perception of “knowing the person” which was said to result in an

accurate prediction of outcomes. As identified in the previous theme, professionals shared responsibility of clients' decisions and it could be suggested that comprehensive information were used to justify decisions made by the team.

In contrast to the above statements, attendees across all teams reported that gathering comprehensive information was “off-putting” and an unhelpful demand. Attendees reported that they acknowledged that professionals may disengage from team formulation as gathering comprehensive information for this process may prevent them from undertaking other demands of their work.

Exploration of ideas.

Participants reported that team formulation led to ideas on how to work with challenging client presentations. Attendees reported that this was a “luxury” as they did not usually have opportunities where professionals contributed their ideas to their clinical work. They reported that exploring ideas and ways of working was helpful because it led to hope and inspiration on how to work with clients (e.g., Team C). In contrast to this, attendees highlighted that if ideas from team formulation led to more demands, they felt frustrated with the process. Attendees across all teams reported that they did not expect to feel increasingly overwhelmed following team formulation because of further demands (as illustrated below). If the ideas derived from team formulation led to this, attendees reported they considered this a disappointing and unhelpful aspect of team formulation.

Mary: I felt equally as frustrated at the end as I did at the beginning because (.) there was probably more work to be done (.) cause people will come up with very creative ways to become unstuck ... to hang on to hope for this person which inevitably (.) had work attached to it

Mary: = people can say ooo you can do this... yeah I could thanks (.) I've just had enough

Lisa: =but you're worn out ...

Lisa & David: [yeah mmm mm]

Lisa: = the idea (of team formulation) is to make working with difficult people a bit more manageable really

Team A

As indicated above, Lisa reported that other demands resulting from the ideas of team formulation were unhelpful particularly as Mary had “had enough”. This suggests that when professionals “felt stuck” there was a sense of feeling unhappy and ‘tired’ of the situation, as indicated by Lisa who stated the feeling of being “worn out”. Lisa and David agreed with Mary suggesting that the main purpose of the process was to support attendees who were experiencing difficulties with their clients with the aim of alleviating overwhelming feelings. Psychologists reported being mindful of the effect of overwhelming ideas and reported using plans to ensure that ideas derived from team formulation were achievable [see below and within Journal paper: Results].

Psychologist Rose: I would look at some of the lists of ideas and it would be like we need to look at this and this and this (.) and it was just a bit like OH MY GOD if I was being presented with that where would I start (.) that’s where I kind of felt that if I can focus on like ‘brilliant (.) you have come up with some fantastic ideas lets just put those down there’ (.) where are we at now

Risk management.

Attendees reported that other professionals helped them consider alternative ways of managing clients’ risk. This was considered a ‘luxury’ as it was not within attendees’ practice.

Laura: = the positive risk taking is something that we have actually planned in (following the team formulation) as part of our areas to move forward with (.) we have for instance erm (.) changed two- person visits to one-person we have (.) sort of change things around risk and around sort of personal safety and everything

Kate: and questioned whether we're being risk averse ...

Laura: it does throw that question ... is it that that's holding them back ... (.) we have been taking a few more risks with people (.) and

Jacob: but even are you feeding (.) something with the person are you feeding the place where they are right now by being risk averse [or]

Laura: [exactly yeah]

Jacob: our own behaviours or our intervention is that maintaining that undesirable lifestyle of whatever that is

Team C

As identified in the previous extract, and across all focus groups, attendees stated that their ways of managing risk may have maintained clients' difficulties. Attendees reported that team formulation helped them question their risk management. They reported this was helpful in planning how to best support their clients, which at times meant engaging with this risk.

Although alternative ways of managing risk were discussed as a helpful aspect of team formulation, attendees across all focus groups reported that they required the support of their team members for these to be undertaken. This identifies the potential influence of shared decision making and responsibility in the implementation of alternative risk management. It is also implied that disapproval from team members may highlight that the task may be unsafe or too risky.

Kate: I've certainly had situations where I have formulated a client and (.) discussed this with the consultant and the consultant has perhaps dismissed that formulation and the risk plan (.) and you can feel quite powerless in that situation but you sort off power ahead regardless (.) I don't know if that's fair really

Craig: = I know what you are saying (.) I mean as Kate was saying earlier (.) it has to have all the people buy into the idea of formulating and (.) it involves risk

Kate: =I was going to say it involves risk doesn't it (.) because information can often help you take therapeutic risk with people can't it (.)

but then if you have someone else coming in and saying actually do you know what I'm not prepared to take any risks then I think that formulation can go out of the window [((laughter))]

Craig: [yeah yeah absolutely] =if you do have people that are risk averse and do all they can to prevent you from taking any risks (.) then it pretty much squashes it doesn't it

Team B

In the above extract, note Kate's hesitancy in indicating that alternative risk strategies not supported by the whole team may not be implemented. She begins her statement by stating that she may "power ahead" despite the strategy not being accepted but then later states that it would "go out of the window" after this was confirmed by Craig that ideas from team formulation were associated with risk. This extract indicates that not implementing alternative risk strategies may occur but may not be usually discussed with other team members. Participants' reports also suggest the imminent impact on the alternative risk management plan when these are not supported by the whole team. This implies the powerful influence other team members may have in the utilisation of alternative risk management plans.

Validation

Attendees reported that professionals' contributions in validating their experiences during team formulation were a helpful and a pleasant aspect of the process (e.g., Team C). In all the focus groups, attendees reported that this was not part of their normal way of working, as they were usually expected to contain their frustrations, as indicated below.

Jacob: knowing how Laura feels about working with an individual that we've got on our caseload sometimes those conversations don't take place and we are not used to them (.) and you don't realise the impact that working with this individual may have on yourself and your colleagues (.) so it's just sometimes it's quite reassuring as well in that you're not alone in feeling the way you do having to work with some of

the difficult people that we work with (.) you feel you do not have to bottle your feelings

Team C

Attendees also reported that when team members experienced opposing emotions regarding a client, team formulation helped in understanding and validating their experiences. Psychologists reported that these experiences were perceived as “useful information for the formulation” (e.g., Psychologist Rose).

Attendees reported that receiving positive feedback from others during team formulation was helpful and pleasant, as they did not usually have these opportunities. They also stated that they felt validated when they believed that others understood that they had “done everything” for the client (Team C).

Kate you're given that (.) reassurance when you think well actually we're not doing anything you're given that positive reassurance (.) 'yeah you've done this (.) this has made some improvement' (.) so it does make you feel well actually it's not all lost and it has made some kind of headway

Team C

Psychologist Rose: yeah just sometimes when we have gone through formulation and ... actually saying with what we are faced with (.) there is nothing more you can be doing at this moment and what you are doing to try and stay in contact with that person is really good (.) you know that's ... validating

As indicated in the above extract, there were consistent reports from attendees who stated that team formulation allowed them not to resume clinical work and they felt relieved and supported by others in these decisions. It is interesting to find that this was perceived as helpful in such situations but also perceived as unhelpful when it prevented them undertaking their work (as identified in the

‘position of team formulation’ theme regarding the ‘braking’ response). This suggests that resuming clinical work was perceived as helpful when attendees required this justification; particularly if they believed there was “nothing more” they could do to support the client (as illustrated above). The relief implied in this also suggests that this may have served a purpose in managing difficulties experienced by attendees.

The validation subtheme was the only one of the five subthemes in this theme that was not reported as presenting with unhelpful aspects. This could be because when being validated attendees may not expect further demands from this and to be challenged by other participants. These aspects have been reported to be unhelpful by participants in this study.

This main theme regarding the luxuries of team formulation identified that although participants predominantly reported helpful aspects of team formulation, these experiences could also be perceived as unhelpful; apart from the validation subtheme. For example, although attendees reported that team formulation was helpful in enabling an alternative perspective, this in itself was unhelpful for some professionals who felt insecure.

In all of these ‘luxuries’, participants reported the contributions from other professionals as enabling the helpful aspects of team formulation e.g., other professionals validating the experiences of attendees. Participants’ reports also indicated that the main benefit of these ‘luxuries’ was related to feeling less ‘stuck’ with their clients e.g., understanding their own emotions meant they could understand their clients, resulting in positive staff- client relationships. In addition to this, other factors that attendees reported may lead to helpful aspects of team formulation included the (1) resilience of attendees, (2) support from the team and team leader, (3) the level of demands of the helpful aspects and (4) psychologists’ intervention e.g., plans to help manage overwhelming ideas.

Attendees reported that the ‘luxuries’ of team formulation impacted on their clinical practice, as these (1) provided alternative ways of working with clients

(identified in the broadening understanding, exploration of ideas, risk management subtheme) and (2) justified the discontinuation of clinical work (identified in the validation subtheme).

EXTENDED DISCUSSION

This study makes novel contributions to our understanding of team formulation within CMHTs. This section considers the transferability of the study findings, embeds these findings within the context of previous research findings, clinical psychology documents and psychological theories to explain some of its findings. Suggestions for clinical practice and future research are made. In conclusion, an evaluation of the study and my critical reflection of the research process are presented.

Transferability

The concept of transferability concerns the applicability of the findings to other contexts (Anney, 2014; Jeanfreau & Jack, 2010; Willig, 2013). Transferability within qualitative studies has remained a contentious issue. Some researchers have argued that qualitative projects are specific to particular environments; therefore, it is impossible to demonstrate how they are applicable to other situations (e.g., Shenton, 2004). On the contrary, other researchers have held a view that transferability should not be immediately dismissed but should be pursued with caution, so not to belittle the importance of contextual factors that may impinge on the phenomenon (e.g., Willig, 2013). Researchers state that the results of a qualitative study should be initially understood within its context (Anney, 2014; Willig, 2013). Following this understanding it is then possible to assess the extent to which these findings can be applied to other settings (Shenton, 2004).

Qualitative researchers have argued that it is not expected that the researcher should identify in which contexts the findings can be applicable (Shenton, 2004). However, it has been considered the researcher's responsibility to provide both a detailed description of the contextual factors and thick

description regarding the methodology (e.g., Krefting, 1991; Shenton, 2004). It is expected that this information would assist readers to determine where the findings can be applied (Anney, 2014; Merriam, 2009). In this research I have met my responsibility as a researcher by ensuring that readers are provided with this information. It is hoped that the contextual information presented on Table 8a and 8b and the extended methodology section of this research document meets this requirement.

In the following sections I initially discuss how my findings may be transferrable to other services, particularly those that already work together and utilise the Newcastle model and a systemic approach. In this discussion, I also identify the aspects that differ between these initiatives and my findings. Following this I discuss how my research findings might be applied to other settings, including other CMHTs and acute inpatient settings. My findings may be applicable to these settings, whilst the data collected presents unique characteristics of the participants, e.g., location and organisations that might potentially have their own cultures. This is because participants raised salient contextual issues regarding both the complexity of the clients and their limits to time and resources, which may be transferrable to these settings.

Relatively few empirical studies of team formulation have been published, as noted in the extended introduction. However, distinct team practices which overlap to some degree with the kind of team formulation discussed in this thesis have been reported, and offer useful points of comparison for assessing the transferability of recommendations made here. I focus upon the Newcastle model (Jackman & Beatty, 2015; Stamper & Excell, n.d.) used in older adult services, and a systemic approach to team working in services for adults with learning disabilities outlined by Kaur & Scior (2009). Reports of these practices are largely descriptive, lacking high quality evaluation, so the comparison is between published expert recommendations on the one hand, and the results of the focus groups and interviews reported here.

The purpose of the Newcastle model, the use of a systemic approach and team formulation are similar in that they aim to offer an explanation and

understanding of a problem, with the hope that this would result in an intervention (e.g., Curtis & Dixon, 2005; DCP, 2011; Dallos & Draper, 2010; Fredman, 2006; Jackman & Beatty, 2015). Team formulation differs to the Newcastle model and a systemic approach in that these two initiatives are psychological frameworks used to understand clients' problems with a specific focus. The Newcastle model is a bio-psychosocial model used within older adult services to understand clients who may be presenting with behaviour that challenges the team (e.g., Jackman & Beatty, 2015). Teams that use the Newcastle model are reported to consider the client's physical health, life history, medication, cognitive impairments and social environment in order to develop an understanding of the client's challenging behaviour (e.g., Jackman & Beatty, 2015). Whereas, a systemic approach is a psychological model that helps professionals understand a difficulty in a system by involving not just the individual but the system (Dallos & Draper, 2010). This approach also suggests that the 'problem' may be existing in interaction and communication between people rather than existing within individuals (Dallos & Draper, 2010). Although the two initiatives may differ according to the model underpinning them and team formulation may not have a specific psychological model attached to it, these initiatives hold a similar function in enabling the development of a psychological formulation and governing an intervention. In the following section I will compare and contrast the available published literature regarding these two initiatives with my study findings.

The Newcastle model is similar to the findings reported in this study in the way in which clients' difficulties are understood. However, these ways of working differ to teams who may utilise a systemic approach. Both the Newcastle model and the findings regarding team formulation indicate that clients are seen as presenting with a problem that requires 'managing' (e.g., Jackman & Beatty, 2015). Participants in my study identified clients who they required support for as they were 'stuck'. These frameworks map the problem as within the client and this may be considered as a move towards pathologising individuals, an aspect which both team formulation and the Newcastle model is expected to move away from (e.g., Boyle, 1999; Johnstone, 2000; Jackman & Beatty, 2015). In contrast, Fredman (2006) and Kaur and Scior (2009) reported that

professionals who used a systemic approach viewed individuals' distress as both interpersonal and serving a function within a system. Therefore, a systemic approach does not consider the 'problem' as within the individual but the system (e.g., Dallos & Daper, 2010).

The Newcastle model and the use of a systemic approach differ to the way of working discussed in my thesis, in that these approaches are often reported to be embedded within the way the team function. The Newcastle model has now been embedded in a number of older adult NHS services (e.g., Stamper & Excell, n.d.). There are now services within the UK that promote themselves on the basis of being driven by this model (e.g., Stamper & Excell, n.d.). Furthermore, Kaur and Scior (2009) reported an increase in learning disability services using a systemic approach. In contrast to this, my findings identified team formulation as separate and distinct from the way the CMHTs worked.

I should note that practice based articles have reported that professionals who utilise the Newcastle model are more committed and engaged in this way of working (e.g., Jackman & Beatty, 2015); whereas services that utilise a systemic approach have reported experiencing difficulty in professionals committing and engaging in this practice, as this approach was not prioritised (Kaur & Scior, 2009). This is consistent with my findings as team formulation was reported as a 'low priority' and not perceived as part of the professionals' work.

The above sections show how team formulation may overlap to some degree with other practices (e.g., the use of both Newcastle model and a systemic approach). Further evidence indicates that my findings may be transferrable to other settings, such as other CMHTs because of similarities in the clients' complex presentations. CMHT professionals reported that their work was often fast-paced and they were often reactive to their clients' needs. Whomsley (2009) has reported that this reactive and fast paced way of working was evident in these settings because of the unpredictability of the client group. Studies have found consistent reports across the UK indicating that CMHTs are increasingly feeling stressed and burnout as they manage risky and

unpredictable clients (e.g., Carpenter, Schenider, Brandon & Wooff, 2003; Edward, Burnard, Coyle, Fothergill & Hannigan, 2000). Therefore, it is unsurprising that the strains that CMHTs face inadvertently impact on their engagement in team formulation. The findings from my research may be beneficial for CMHTs interested in embedding team formulation, as this research highlights the potential challenges that may be faced.

Although the limits regarding staff members' time and resources is widely transferrable to a number of teams within the NHS, the added implication regarding the complexity of clients leads me to consider that my findings may be applicable to other CMHTs and acute inpatient teams. A multi-method study undertaken by the National Institute of Health Research found that CMHTs and acute inpatient mental health settings showed significant psychological strain as a result of high demands and low managerial support (Johnson et al., 2011). This study compared other settings such as rehabilitation settings and it was concluded that these settings had lower levels of stress and burnout compared to CMHTs and inpatient settings (Johnson et al., 2011). Rehabilitation settings were found to be resourceful and the client group was suggested to be less demanding than those presented in CMHTs and acute inpatient settings (Johnson et al., 2011). When considering the context in which my research was undertaken, it is perhaps unsurprising that team formulation was considered a 'luxury', 'a low priority' and distinct from the way staff members' worked. My study captures the contexts and challenges faced in CMHTs and acute inpatient settings. This study may further assist readers to consider the potential challenges that could be faced when engaging staff members in team formulation.

The following section (see Reference to Previous research) identifies how some of my results were also found within MDTs embedded in inpatient settings. This further indicates the potential applicability of these findings in these settings. Therefore, professionals working within inpatient settings who may be involved in team formulation may be interested in the theoretical and clinical implications identified in this study.

Reference to Previous Research

The position of team formulation.

This main theme addressed research questions (1), (2) and (3), namely, what is the impact of team formulation on professionals' clinical practice, what are considered helpful and unhelpful aspects of this process and what are the factors that may influence engaging in this process and subsequently the ability to access the helpful aspects of the process.

It was interesting to find that although only two studies had found that professionals identified team formulation as different to their way of working but had not offered an explanation for this, these studies had either inpatient (Summers, 2006) and CMHT (Hood et al., 2013) participants. This indicates the potential applicability of these findings beyond CMHT settings. This study identified the influence that psychiatry still had on the CMHTs' way of working and helped us understand the impact of the 'braking' response on professionals' practice. This study identified that a minority of attendees found the 'braking' response of team formulation as an unhelpful aspect, if this did not influence attendees' work or lead to action. This is in line with articles on team formulation such as Lake (2008a) that expect this process to inform an intervention to meet clients' needs and support professionals to work effectively with their clients. Therefore, these unhelpful aspects of team formulation may be perceived when the process is not meeting its expectations or purpose.

This study also identified factors that may influence the initial engagement of team formulation and subsequently the ability to gain un/helpful aspects of this process. These factors included the (1) 'braking' response of team formulation perceived as incongruent to normal work, (2) extent to which the benefits of team formulation could be accessed elsewhere, (3) its low priority against other demands and (4) the perception that engaging in team formulation was both optional and engaged by those who valued the process. These are new findings not currently supported by previous research.

Associated risk.

This main theme addressed research questions (1) and (2) regarding what are considered helpful and unhelpful aspects of team formulation and the factors that may influence the un/helpfulness of this process.

This study identified that attendees required team formulation to be a safe environment, where they would not be criticised or deemed incompetent for discussing their difficulties with specific clients. Studies that have either focused their research on professionals working within inpatient settings (Summers, 2006; Wainwright & Bergin, 2010) or requested the clinical psychologists' perceptions of the process (Christofides et al., 2011) indicate a point of agreement that team formulation is a safe environment. However these studies did not discuss the function of this safe environment and ways of developing this. The concept of safe environments have also been identified to be experienced in meetings such as reflective practice groups (Collins, 2011), staff support groups (Haigh, 2000) and during training programmes (Ingham et al., 2008), and with minimal reflection on their function or ways of embedding these. My study identified that attendees were anxious about engaging in an unsafe environment that may threaten their job security. Furthermore, this study presented novel findings regarding (1) psychologists validating attendees' experiences with their clients and (2) the support of team leaders as both helpful aspects in building a safe environment and important factors in the initial development of team formulation. This study identified the function and helpfulness of safe environments during team formulation. This study also contributed a novel finding regarding team formulation providing a setting to share responsibility and decision making for risky and difficult clients. This shared decision making was reported to reassure attendees of the security of their jobs, as decisions were made by the team.

A "luxury"?

This main theme addressed research questions (1), (2) and (3) namely, what are considered helpful and unhelpful aspects of team formulation, the factors

that may influence the un/helpfulness of this process and the impact of team formulation on professionals' clinical practice. In the following section I will show how the findings from this theme concurred with other studies. I will also critically discuss these findings in the context of their studies.

1. Participants in my study reported that team formulation broadened both their understanding of clients' difficulties and the professionals' emotion relating to their clients. This finding is common in 12 other studies on team formulation. However, a number of methodological problems bring into question the validity of this finding. These problems include (1) this finding being presented as an opinion of the clinical psychologists facilitating these meetings (Christofides et al., 2011), (2) the involvement of the team's psychologist in the data collection and analysis (Ingham & Clarke, 2009; Hewitt, 2008; Robson & Quayle, 2009; Wainwright & Bergin, 2010), (3) the presentation of the finding as a summary statement without further detail, therefore bringing into question its credibility (Summers, 2006) and (4) this statement having been imposed on the participants as found in Hollingworth and Johnstone's (2014) survey research. Although this result was found across 12 studies and across different settings including inpatient (e.g., Murphy et al., 2013) and CMHT settings (Craven-Staines et al., 2010; Hood et al., 2013), my evaluation of the above studies indicates the difficulty in taking too much confidence from this replication.
2. The study's finding regarding team formulation enabling a shared understanding of clients with other team members was identified in four articles. Apart from Summers (2006) article, the validity of this finding within the other three studies is brought into question particularly as the clinical psychologists who were undertaking these meetings were also involved in the data collection and analysis. This may have resulted in social desirable responses and biases during data analysis (Ingham & Clarke, 2009; Hewitt, 2008; Wainwright & Bergin, 2010).

3. The study's finding regarding team formulation enabling information gathering was supported in two studies by Craven-Staines et al. (2010) and Hollingworth and Johnstone (2014). However, as indicated in the previous section it is unclear of the helpfulness of this aspect within Hollingworth and Johnstone (2014) survey research as participants were not given alternative perspectives of this. Craven et al. (2010) study identified that this aspect of team formulation was perceived as helpful for both inpatient and CMHTs, further indicating the applicability of this finding.
4. The study's findings regarding team formulation enabling the exploration of ideas by utilising other professions was identified in three studies. This finding was identified across inpatient (Murphy et al., 2013; Robson & Quayle, 2009; Summers, 2006) and across both inpatient settings and CMHTs (Craven-Staines et al., 2010).
5. Although the study's finding regarding team formulation enabling alternative ways of managing risk was supported by Hollingworth and Johnstone (2014) and Summers (2006); these studies did not detail the impact of this within the professionals' practice. Professionals in my research reported positive risk taking and influence of shared decision making during this process.
6. The study's finding regarding team formulation providing validation from others when experiencing difficult emotions was found to be supported in one study by Murphy et al. (2013). As identified in my study, Murphy et al (2013) offered an understanding that team formulation provided a space in which staff members' difficult emotions could be acknowledged and accepted, which was different to their usual way of working.

This study identified original findings regarding other helpful aspects of team formulation, which included positive feedback on professionals' work and feedback sometimes being used to justify discontinuation of clinical work.

This study identified that the helpful aspects of team formulation were related to attendees feeling less 'stuck' about their clinical work e.g., understanding their own emotions meant they could understand their clients, resulting in positive

staff-client relationships. This finding is supported by articles on team formulation that expect this to be a purpose of this process (e.g., Hollingworth & Johnstone, 2014; Murphy et al., 2013).

Some of the helpful aspects of team formulation found in this study could be accessed in other meetings including reflective practice groups (Collins, 2001), support groups (Haigh, 2000) and training programmes (Schweitzer et al., 2007). The main component that differentiates team formulation from these meetings is the use of psychological theory to enable a psychological understanding of clients' presentations (e.g., DCP, 2011; Whomsley, 2010). However, this was not highlighted by attendees in this study; therefore the helpfulness of this was not determined. This is also perhaps a concern that the unique aspect of team formulation was not articulated by attendees in this study.

This research helped us to understand that although participants predominantly reported helpful aspects of team formulation, these experiences could also be perceived as unhelpful (apart from validation). For example, although attendees reported that team formulation was helpful in enabling an alternative perspective, this was considered unhelpful for some professionals who felt insecure and uncomfortable with having their perspectives challenged. These were original findings not supported by previous research, particularly as articles on team formulation mainly focus on the positive and helpful aspects of this process. As discussed in the introduction section, this could have been a result of participants either not being requested to report the unhelpful aspects of team formulation or feeling inhibited because of the involvement of the teams' psychologists during the data collection.

This study found consistent reports from participants emphasising the positive role of other professionals' contributions in supporting attendees to gain helpful aspects of team formulation e.g., exploration of ideas required others' contributions. Authors of team formulation have suggested that team formulation requires MDT involvement; however, the helpfulness of this was not identified. The validity of this finding is brought into question from these articles.

Most of these articles presented clinical psychologists' opinions rather than published evidence base (Ingham & Clarke, 2009; Jackman, 2013; Shirley, 2010; Walton, 2011) and one article utilises a survey research in which participants were requested to rate the helpfulness of this aspect (Hollingworth & Johnstone, 2014). This research identified novel findings regarding other factors that may influence the helpful aspects of team formulation. These included (1) the resilience of attendees, (2) support from the team, (3) support from the team leader, (4) the demands of the helpful aspects and (5) psychologists' intervention in managing attendees' challenges in engaging in this process.

This research found that the 'luxuries' of team formulation impacted on attendees' clinical practice as it enabled attendees to work effectively with their clients. Murphy et al.'s (2013) participants based within inpatient settings also reported that team formulation enabled a better understanding of the clients resulting in the professionals' ability to work effectively with their clients. This finding was also supported by Hollingworth and Johnstone (2014) survey research. However the validity of this finding has been brought to question as participants were requested to tick the helpfulness of this aspect on a Likert scale and the mean scores were reported. It is not considered that these mean scores may be affected by outliers. Furthermore, my study also found a novel finding that team formulation led to the discontinuation of clinical work.

In conclusion, this study also presented a new finding identifying that the benefits of team formulation could be perceived as a 'luxury'. This was defined by attendees as something that was a pleasant experience and both not considered as their normal way of working or part of their work and prevented them from meeting their work demands.

Reference to Clinical Psychology Documents and Implications

Team formulation is expected to support professionals to work effectively with their clients, to inform an intervention to meet clients' needs and to broaden MDT members' psychological understanding (e.g., BPS, 2010; Christofides et

al., 2011; DCP, 2011; Onyett, 2007). This study's findings suggest that team formulation is meeting two out of three of its expected outcomes. CMHT participants in this study reported that other professionals sharing their ideas and knowledge during team formulation enabled them to work effectively with clients, especially with those they previously felt 'stuck' with. This was presented in the Journal Paper regarding the helpfulness of care plans derived from team formulation and also in the sub-themes relating to the 'luxury' of team formulation, including broadened understanding and exploration of ideas. Participants in this study also identified that team formulation enabled them to inform intervention to meet clients' needs. These reports were identified in relation to the care plans derived from the team formulation that were perceived as a vehicle to meet clients' needs (see Journal Paper Results). It was also discussed in the reports relating to the alternative risk management subtheme, whereby attendees reported that alternative risk management plans derived from team formulation were most appropriate to meet their clients' needs. However, in this study, attendees did not report having broadened their psychological understanding or knowledge as a result of engaging in team formulation. Although this study utilised a small, homogenous sample, it cannot be assumed that this finding would be representative of all other CMHT teams without future research being undertaken. However, according to the epistemological stance adopted in this study, there may be some truth in this finding, although larger, more geographically diverse samples may need to assess this. Nevertheless, this finding brings into question the expectation outlined by the DCP and the BPS regarding clinical psychologists supporting their MDT colleagues to broaden their psychological understanding during team formulation. It could be argued that this expectation and the pressure to promote team formulation as the profession's unique contribution to MDTs is a reflection of the professions' own preoccupation to secure a more stable and recognised status within the NHS (e.g., Pilgrim & Treacher, 1992). However, as indicated by Howarth (1988, p. 98) it is important for the profession "not to make claims beyond its competence as this could threaten its credibility". Due to the limitations of this study, it is important that more research is undertaken to understand the impact of team formulation with regards to broadening MDT members' psychological knowledge. Until then, the DCP and BPS may need to

consider their statements regarding clinical psychologists' role in broadening their MDTs' psychological knowledge, particularly as there remains a lack of research evidence confirming this.

Theoretical Implications

Mental models

The benefits of applying the theory of mental models in relation to team formulation is that it enables us to assess participants' mental models and the subsequent influence on the effectiveness of the process.

In the following section I discuss how the theory of team mental models, as discussed by Cannon-Bowers and Salas (2001) has helped us understand the findings from this study.

Participants appeared to hold a shared team work mental model regarding expectations that other professionals would contribute to the process and the required support of the team leaders. The theory of mental models would suggest that this shared team work mental model may have structured the process (e.g., Cannon- Bowers & Salas, 2001; Mohammed & Dumville, 2001).

Shared mental models regarding the disparateness of team formulation in comparison to professionals' normal way of working were identified in this study. It is therefore unsurprising to find reports regarding the difficulties experienced in both prioritising this process and implementing plans derived from these meetings (see section on Associated Risk and Journal Paper). The theory of mental models also helps us to identify the dissimilar mental models held by attendees and psychologists. These were regarding both the implementation of ideas and perceptions of the helpfulness of some aspects of team formulation. The theory of mental models would predict that dissimilar mental models would have negative consequences on the effectiveness of the practice (e.g., Cannon-Bowers & Salas, 2001; Klimoski & Mohammed, 1994; Lim & Klein, 2006). However, in this study it was not made explicit what goals

were expected regarding the implementation of the CPs and whether not meeting these would be classed as ineffective practice. Furthermore, participants did not indicate the implications on patient care as a result of professionals holding different expectations of the process.

The theory of mental models would predict that difficulties in integrating team formulation within attendees' way of working may be a result of the (1) shared mental model regarding the incongruence of team formulation to attendees' way of working and (2) the dissimilar mental models regarding the helpfulness or the factors that influence this. The theory of mental models would imply that compatible and similar knowledge would need to be disseminated (e.g., Levesque et al., 2001; Mathieu et al., 2000). This may enable a shared mental model consistent with a shared goal (e.g., Hannigan, 1999; Lim & Klein, 2006).

A limitation of the theory of mental models is that this does not consider that team formulation may serve a different function and its effectiveness may not be based on a team attaining a shared goal but rather individuals' fulfilling their individual goals. In the following section, Wenger's (1998, 2000) psychological construct regarding 'communities of practice' (CoP) will be used to interpret the study's findings. This construct helps us to understand how team formulation, as described by CMHT participants in this study, fulfils the criteria of CoP, although this conflicts to an extent with their current practice, and may enable professionals to attain individual goals. In addition to this, Weiner's (1980, 1985) theory of attribution is used to interpret findings regarding the impact of alternative perspectives reported by participants in this study.

Communities of practice (CoP).

The term, communities of practice (CoP) was originally developed by Lave and Wenger in 1991 to explain how apprentices developed their knowledge when they interacted with others. Since then Wenger (1998, 2000) and Wenger and Snyder (1992) have further developed this framework to understand how knowledge is shared within a range of organisational frameworks. Wenger and Snyder (1992) and Wenger (1998, 2000) define communities of practice (CoP)

as groups of people who share concerns, problems or a passion and deepen their knowledge and expertise through ongoing interactions. This definition emphasises the role of others as essential in collective learning and knowledge development. The concept of CoP is embedded within the social learning theory, locating learning and development in the relationship between the person and their interactions with the social world (Hoadley, n. d., Wenger, 2000).

Wenger (1998, 2000) had outlined that CoP require three crucial characteristics in order to function. These include (1) a shared domain of interest which outlines the fundamental purpose of engaging in the process, (2) a community in which members engage in discussions to pursue their domain of interest and (3) a practice which are the shared repertoire of resources, tools, or processes that are used to pursue the development of knowledge. Hara and Schwen's (2006) study on a CoP of public defenders found five attributes that enabled the CoP to function which were akin to those outlined by Wenger (2000). These included (1) a group of professional practitioners, (2) a development of a shared meaning, (3) an informal social network, (4) a supportive culture in which members aim to support each other by providing practical knowledge to solve problems and (5) engagement in knowledge building. Hoadley (n.d) and Guldberg and Macknesst (2009) have also found that these three characteristics outlined by Wenger (1998) enable virtual/ online CoP to function effectively.

There has been an increase in research into the evaluation of CoP as an intervention to develop skills, as indicated by Ranmuthugala et al. (2011) systematic literature review. Evaluations of CoP have been undertaken in a range of sectors including in health care, education, business and legal institutions (e.g., Andrew, Ferguson, Wilkie, Corcoraon & Simpson, 2009; Li et al., 2009). Studies have found that individual aspects of community members play a major influence in how knowledge is used. Articles on CoP suggest that each community member considers what they find most helpful or unhelpful about the process and from this choose how this may influence their practice (Hoadley, n. d.; Wenger, 1998, 2000). The difficulty in evaluating CoP has been

found to be related to community members' choice in how they utilise their knowledge.

Communities of practice (CoP) and Team formulation

According to the study's findings, team formulation's domain may be related to supporting attendees to work effectively with their clients and assist them to meet clients' needs; and the fundamental value would related to feeling 'less stuck' with regards to attendees' clinical work.

Participants in this study reported that they found other professionals contributions as a helpful aspect in enabling them to feel less 'stuck' about their clinical work. As identified in the theme related to the 'luxury' of team formulation, attendees reported gaining new knowledge and pleasant experiences that they did not normally attain in their work as a result of engaging in this process. These findings are in line with CoP's fundamental assumption that others are an important resource in gaining knowledge and supporting learning (e.g., Li et al., 2009; Merriam et al., 2003; Wenger, 2000).

Attendees identified that a safe environment was required in team formulation to enable them to discuss difficulties regarding their clients and to access support from other professionals. This study identified the factors that could enable this safe environment e.g., psychologists validating their experiences and the support of the team leader. Articles on CoP identify the importance of providing community members with a safe environment to share ideas and ask difficult questions without feeling judged, therefore, aiming to foster a positive learning environment (Wenger et al., 2002).

Understanding team formulation as a CoP may explain why aspects perceived as helpful could also be perceived as unhelpful by other attendees. This indicates that aspects of team formulation can be perceived and experienced differently by attendees in the process. This also helps us understand why psychological contributions were reported to be an important aspect of team formulation by psychologists and not attendees. This could show that team

formulations' domain, i.e., knowledge regarding feeling less 'stuck' in clinical work, constitutes a range of contributions. This further suggests that attaining psychological knowledge or understanding may be an individual experience for each attendee that may not be easily determined, despite articles on team formulation encouraging clinical psychologists to broaden their attendees' psychological understanding (e.g., DCP, 2011; Onyett, 2007). This is because community members would consider what they value during the process depending on their individual needs (Merriam et al., 2003; Wenger et al., 2002).

Team formulation offered something distinct from attendees' normal way of working, as they described it as a 'braking response' and a 'luxury'. CoP are different from teams in that they are not committed to a predefined, shared objective but rather members invest in the interest which the CoP explores (e.g., Ranmuthugala et al., 2011). In each CoP, the practice indicates ways in which knowledge is shared. Therefore, in line with CoP, the team formulation meeting would be considered the practice, as during these professionals have an opportunity to reflect and discuss about clients' difficulties, enabling them to work effectively with their clients (e.g., Lake, 2008a; Whomsley, 2010).

CoP can become part of professionals' work, only if the service managers recognise the knowledge gained as a crucial and key asset (e.g., Merriam et al., 2003; Ranmuthugala et al., 2011; Swan, Scarbrough, & Robertson, 2002). Community members can apply the knowledge gained to benefit their organisations and work, as CoP can identify best practice (e.g., Ranmuthugala et al., 2011; Wenger, 1998, 2002). For this to occur, it is advised that open dialogue between service managers and CoP would need to be undertaken. This study identified the support of the team leader as important in using team formulation as a setting to share decision making and responsibility for difficult and risky clients. This showed that the knowledge gained in this setting was perceived as a key asset for the team.

Organisational structures can also either hinder or enable accessibility of knowledge, (as identified in this study) therefore it is important to ensure that senior managers provide support and resources for CoP (Hoadley, n. d.;

Wenger et al., 2002). Participants reported the conflicts they experienced when team formulation was perceived as separate from their normal way of working and as low priority compared to other demands. Support and resources from senior managers may alleviate such conflicts, enabling professionals to perceive the process as higher priority and part of professionals' work. Participants reported that support from the team leaders were important in permitting them to engage in this process as this reassured them of their job securities.

This study identified that although team formulation does meet the criteria for CoP within CMHTs, these may conflict, to an extent, with professionals' incumbent practice. The benefits of thinking about CoP in relation to formulation and formulation as a process are as follows. Firstly, this thinking enables us to develop our understanding of the function of team formulation. Likewise, CMHTs should have open discussions about the multiple ways in which team formulation may be useful for the community members e.g., a learning opportunity, a space to feel validated. When team formulation is considered a CoP then this may enable professionals to be aware of the challenges that they face as a CoP and consider ways of managing this. For instance, CMHTs that have difficulty prioritising team formulation due to other demands may discuss ways of maintaining their membership within the CoP e.g., virtual participation (Guldborg & Macknesst, 2009). Psychologists may acknowledge that they may not have control over what others take from the process, as this may depend on individual needs. Furthermore, thinking about CoP in relation to formulation and formulation as a process helps us to consider the uniqueness of each CoP as dependent on the community members. This enables us to consider the major influence that community members have on the effectiveness of this process. It highlights the importance of including members in the development and maintenance of a CoP, such as a team formulation.

Weiner's theory of attribution.

As identified in the 'luxury' theme, participants reported that engaging in team formulation resulted in broadened understanding of both their clients' presenting

problems and their own emotional experiences. Participants reported that as a result of this new understanding this assisted them to feel 'less stuck' in their clinical work, enabling them to either work effectively with their clients or discontinue their clinical work. Weiner's (1980, 1985) theory of attribution predicts that a change in attribution enables a change in individuals' emotional and behavioural responses towards others. This study did not explore which mediators may have resulted in such changes, for example perceiving clients' behaviour as not under their control or externally attributed, as indicated by other studies of team formulation (e.g., Berry et al., 2009; Ingham, 2011; Wainwright & Bergin, 2010). However, this study enabled us to understand the potential shift in attendees' emotions and subsequent ways of working following engaging in this process. This study identifies the positive and negative implications of adopting alternative perspectives during team formulation. Participants reported that other professionals could be threatened by alternative perspectives and identified individual characteristics required to benefit from alternative perspectives, including the ability to be resilient and be comfortable with change. Such characteristics were not included in Weiner's theory of attribution. This study indicates that the benefits of alternative perspectives may depend on attendees' own interpretations of the alternative perspective e.g., if the individual considers the alternative perspective as a test of their knowledge then this may lead to anxiety and reluctance to engage in team formulation. This study draws attention to individuals' experiences in team formulation as indicated in the section regarding the CoP. It is expected that individuals' own interpretations of alternative perspectives would impact on their experience of this.

Clinical Implications

The following section presents clinical implications in conjunction with the research findings.

- The findings identified that the 'braking' response of team formulation could be considered an unhelpful aspect. Clear expectations of the process of team formulation should be discussed with attendees. This

would be beneficial as team formulation is perceived as different to other professionals' fast paced way of working.

- If benefits of team formulation are believed to be accessible in other settings, then this should be discussed with attendees to allow them to use their time effectively.
- Findings identified that attendees required team formulation to be a safe environment that does not threaten their job security. Each CMHT should discuss what other aspects would be important for these settings to be safe and ascertain how these could be achieved.
- This study identified that psychologists validated attendees' experiences with their clients and that this was important both in developing team formulation and enabling attendees to access the helpful aspects of team formulation. It is advised that psychologists should continue validating attendees' experiences with their clients and recognising that engaging in team formulation may be exposing and threatening for other professionals.
- Psychologists should consider that although aspects of team formulation could be considered helpful for some attendees, these can also be unhelpful. Therefore, team members should openly discuss these aspects with their teams and agree on ways of dealing with the unhelpful aspects. For example, if gathering comprehensive information is also perceived as an extra demand, therefore unhelpful, ways of dealing with this should be considered. Could utilising less comprehensive information be undertaken? Are there any anxieties about this and how could these be managed?
- Service managers who expect professionals to engage in team formulation should ensure that team members have the time and resources to do so. Discussions need to be held regarding how to enable this process to be perceived a higher priority and part of the professionals' work. Furthermore, service managers who believe the knowledge gained in team formulation is a key asset for the benefit of clients should have discussions with their teams regarding the use of this process.

- Psychologists who facilitate team formulation should consider participating in group supervision (with other psychologists) to voice their difficulties and share strategies to manage challenges in facilitating this process.

Research Implications

This research identified a lack of research evidence regarding team formulation in CMHTs. Future research in this area would be beneficial to explore this under-researched phenomenon. In the following section, recommendations for future research are discussed.

1. Articles of team formulation report that as psychological formulation includes the use of psychological theory and models then this process should enable professionals to broaden their psychological understanding (e.g., DCP, 2011). However, in this research attendees did not report on their psychological knowledge or understanding. It is not understood how important the psychological aspects of team formulation are to attendees. Researchers should provide opportunities for other professionals to reflect on their psychological knowledge and the impact of engaging in team formulation. Researchers are also encouraged to explore ways of evaluating the impact of psychological contributions on team formulation.
 - a. This may be explored by comparing meetings facilitated by psychologists and professionals from other disciplines.
 - b. Researchers should also consider assessing changes in professionals' narratives following team formulation to evaluate their psychological understanding following engaging in this process. This can be undertaken by assessing this pre- and post-attending team formulation.

These findings could identify the role of clinical psychologists in team formulation in relation to increasing MDT members' psychological understanding.

2. Findings relating to the 'braking response' of team formulation warrant further attention. Researchers should consider understanding the function of this using qualitative methodology to enable a rich and in-depth understanding.
3. As indicated in the research, more studies relating to the experiences of psychologists are needed to build on the understanding of team formulation in CMHTs. It would be useful to further understand the challenges and strategies used by psychologists during this process.
4. Participants report the function of team formulation in providing a safe environment which does not threaten their job security. Future research should allow further understanding of what enables participants to obtain safe environments in team formulation. The use of a qualitative methodology could enable this to be explored in an in-depth manner.
5. This study found that the benefits of team formulation such as enabling a safe environment could also be experienced in meetings such as reflective practice groups (Collins, 2011), staff support groups (Haigh, 2000) and during training programmes (Ingham et al., 2008). Future research should compare team formulation with attention-placebo groups, reflective practice groups, staff support groups and individual supervision. This would assist in identifying whether team formulation provides something distinct from other meetings.

Evaluation

A key strength of the study was the qualitative approach used. This enabled a better understanding of team formulation within CMHTs. The combination of individual interviews and focus groups meant a wider breadth of data could be collected. The use of TA also allowed for an in-depth analysis of participants' perceptions collected using both methods. Furthermore, participants' perceptions were voiced with the use of an inductive, semantic and latent analytical approach that helped me to remain immersed in the data. The trustworthiness and credibility of the findings was also ensured by using a number of quality assurance measures. This study was one of the few studies

that provided a number of original contributions regarding team formulation in CMHTs, however, a number of limitations must be considered.

This study utilised a small and homogenous sample of 12 participants from three teams. This sample size would have limited the generalisability of the findings. It cannot be assumed that the themes identified can be representative of the views of professionals in other teams, without future research being undertaken. The epistemological stance adopted in this research, posits that there is some truth in the findings of this study. However, a larger, more geographically diverse sample may further confirm the research findings, therefore expanding on the generalisability of the findings.

The use of purposive sampling method may have risked a biased sample. This is considered as professionals who were willing to volunteer may have been skewed towards a particular view compared to those who did not participate. Although I experienced difficulty in recruiting in this setting due to staff members' busy environments, it is considered that future research could sensitively encourage those who are less likely to volunteer to participate in the research. It may be beneficial to offer less intrusive data collection methods such as telephone interviews, at a time most convenient for professionals.

A number of authors suggest that focus groups enhance openness and disclosure (Gibbs, 1997; Kitzinger, 1995; Morgan & Krueger, 1993; Robinson, 1999; Wilkinson, 1998), however, the opposite of this can also occur influencing what participants say and do not say (Hollander, 2004). I cannot be certain that demand characteristics did not influence the data and participants did not censor opinions that differed from other participants. It is likely that ongoing working relationships amongst the participants could have enabled this inhibition. This may have influenced the findings by introducing dominant ideas in each group, whilst alternative discourses may have been silenced. Additional interviews with the focus group participants could have allowed for alternative views to emerge.

My role as the researcher and a trainee clinical psychologist may also have impacted on participants' reports. Participants could have over- or under-represented their views in this research. As this research was undertaken by me as part fulfilment of my training, it is considered that future research should consider employing a non-psychologist to undertake data collection. This may manage potential social desirable responses.

Critical Reflection

This section critically discusses some of the wider issues raised by this research study. The discussion is organised as a temporal account around themes derived from my reflective research diary. Throughout this section, the main difficulties faced during the research process and ways these were managed are outlined.

Conceptualising the research.

The rationale for undertaking this study came from my previous experience of participating in team formulation and from witnessing an increase in opportunities for clinical psychologists to attend training on this. My interest in team formulation led me to complete a systematic literature review on this topic, focusing on the impact of team formulation on professionals' clinical practice. I was surprised to find there was limited research evidence on this topic and the evidence that was reported presented with significant methodological flaws. I was particularly shocked about this as the DCP (2011) had published these findings in a renowned professional document, using these findings to justify clinical psychologists' role in facilitating team formulation. As the studies on team formulation brought into question the reliability and validity of these findings, I wanted to undertake a study that could address the paucity of research on this topic.

As I had worked in both inpatient and CMHT settings, I was aware of differences in the way professionals worked in each setting. In the CMHTs, professionals appeared to be more confident in their roles and their roles were

differentiated from other disciplines (as supported by Onyett et al., 1995, 1997). Following examining research on differences on CMHTs' way of working compared to inpatient and the challenges in CMHTs, I wondered if such distinction had been considered in the research on team formulation. I found that there had been only one study that had undertaken research on CMHTs' perceptions of team formulation (Hood et al., 2013). This study had not included psychologists' perceptions of facilitating team formulation. As research identifies that clinical psychologists often feel unclear and unconfident in CMHTs, I wondered how they facilitated this process in settings they did not usually feel confident in.

Initially I had two ideas for my research proposal. Firstly I considered focusing on the way in which team formulation was undertaken within a CMHT setting, particularly the conversational strategies adopted by attendees and psychologists. When I shared this idea with my research supervisors, they thought this was a cumbersome project that I may have struggled to undertake in the time frame. I then discussed gathering CMHTs' perceptions of engaging in team formulation, which included perceptions regarding participating in the meeting, the impact this had on their practice and the outcomes that came from this experience following the meeting. I felt it was important to include all professionals who engaged in this process, including the psychologists who were believed to take a facilitative role in the process. Discussions with research supervisors indicated that this study idea was feasible.

The next stage was to assess the feasibility of this study. Following sending an email to the clinical psychologists employed within the course to assess if psychologists who also work in CMHTs may be interested in this study, I received a response from one of the psychologists (SS) (who subsequently became my field supervisor). She sent the email round to other psychologists who worked within CMHTs. In a month's time I had made contact with three keen psychologists who wanted to participate in the study and were willing to help me with recruiting their colleagues. Following telephone and email contact with these psychologists regarding participating in this study I was surprised to find these psychologists were very motivated to support me in this research

because they also wondered what other psychologists and their MDT colleagues thought about engaging in team formulation. There were consistent reports from psychologists who considered whether this process was helpful or unhelpful or if it had any impact on their MDT colleagues' practice. I recall pondering similar questions, which were then constructed within the schedule of questions used during the data collection. The psychologists also reported feeling "pressured" to provide team formulation as this was now part of their roles and responsibilities and also reported that this was a challenging process to integrate in CMHTs. There was consistent reference to the DCP (2011) guidelines that emphasised clinical psychologists' role in facilitating these meetings. I speculated about the powerful influence these professional documents have in encouraging psychologists to facilitate team formulation, with insufficient evidence regarding this practice.

With regards to the feasibility of the study, the three psychologists who I had made contact with stated that their main worry was regarding recruiting their MDT colleagues to participate in the study. They reported that their MDT colleagues were very busy and given the ongoing expenditure cuts, were experiencing high demands for their service. I became concerned about their ability to commit and participate in the study and I had to remind myself that qualitative research was not aimed at recruiting large samples to produce objective, generalisable findings, but rather in-depth good quality subjective accounts that would enable an understanding of the under-researched phenomenon.

A number of decisions.

This section will outline a number of decisions made regarding the methodology.

Due to the lack of research evidence on team formulation within CMHTs, I decided that the research questions would be left open so not to limit data collection and analysis. Therefore, the present study aimed to answer the following research questions, (1) what are considered helpful or unhelpful

aspects of team formulation by CMHT professionals, (2) what are the processes or mechanisms (factors) that lead to unhelpful or helpful aspects of team formulation, (3) what is the impact of team formulation on professionals' clinical practice and (4) what are the factors that may influence these outcomes. By leaving the research questions open, I hoped that the participants would not be constrained in their responses and this would allow a rich and in-depth understanding of team formulation within CMHTs. The open research questions also reflected the schedule of questions and the topic list presented to the participants to orientate them to the study (see Appendix B: Schedule of Questions; Appendix C: Topic List).

As the research aimed to gather perceptions from professions who attend team formulation, I wanted to enable a range of professionals to participate in this process. As studies identified the role of psychologists as facilitators of team formulation, I was faced with the decision of including psychologists in a way that would not influence other professionals' participation. I decided to conduct focus groups for psychologists' MDT colleagues, as participants could utilise the discussions to confirm or contradict others' views. As there remains a lack of research evidence on CMHT professionals' perceptions of team formulation I hoped that this forum would enable attendees to discuss the phenomenon with minimal intervention from me. I decided that clinical psychologists would be invited to individual interviews to minimise the influence they had on their colleagues' discussions.

Given that I was interested in exploring professionals' perceptions of team formulation and identifying my epistemological stance as a contextualist, critical realist; I needed to select a method that would allow full exploration of the data from interviews with the psychologists and focus groups with their MDT colleagues. I chose TA as this method could assist me in analysing and synthesizing large quantities of qualitative data and afforded considerable flexibility in the application of this method. I was conscious that TA has been criticised for lacking clarity and potentially resulting in limited interpretative power, however, comparing it to other methods of analyses I felt that this was useful in addressing my research questions. Group interactions has been

described as an underused and underreported source of data in focus group research, with focus group data often presented as if they were one-to-one interview data (Wilkinson, 1998). Therefore I was keen to incorporate this into my TA by coding this in the margins (e.g., challenging, agreement, defending, reinstating) (see Appendix N: Sample of Analysis 1: Focus group data). The findings were integrated within the themes and used to enrich understanding of convergent and divergent participants' reports.

Ethics and R & D.

I did not expect the process of gaining approval from the Ethics Committee and the R& D departments to be as straight-forward as I experienced. This could have been enabled by the prompt responses from the clinical psychologists who had agreed to support me during recruitment. Furthermore I felt that the systems from the two different R& D departments were very clear and I did not face any difficulties in this process.

Data collection.

My preparation for moderating the focus groups commenced when I read Krueger and Casey (2000) and Krueger (1994). The authors emphasised that researchers should adopt a low moderator approach, which encourages the group to engage in a discussion with each other with minimal intervention from the researcher. This was in line with the epistemological stance adopted in this study that assumes knowledge would emerge from the social contexts. In order to prepare for this, I kept to a standardised procedure in the way I would moderate the focus groups. This included stating at the beginning of the focus group that I was more interested in the participants' discussions amongst themselves and that I would ask questions less often as they might expect. I produced a topic list from the schedule of questions I had constructed to orientate the focus group participants to the topic (see Appendix C: Topic list). I emphasised that this was a guide for their discussions. The topic list assisted participants to shift from expecting me to "lead the focus group" and I also felt relaxed in this position.

During all the focus groups I noticed that there were often one or two dominant participants, meaning that some participants would speak very minimally. Although this gave me information regarding the dynamics of the group, I felt that not acknowledging and encouraging these individuals' views to be heard may result in a gap in the data. Therefore in these situations I would directly ask "what are your thoughts about this?" without indicating that these had to be different from other participants. This led to further interesting, often conflicting data reported by participants resulting in divergent aspects of the topic.

I experienced an interesting shift in my role as a researcher when I was undertaking the interviews with the psychologists as then I had to take a more active role in presenting probing questions regarding psychologists' accounts. I also shared the topic list with the psychologists which I had presented to the focus group participants to orientate them to the topic. As I had never undertaken research interviews, this was a learning process for me. In particular as the psychologists were aware of my role as a trainee clinical psychologist, I felt they expected me to adopt a therapeutic interviewer role rather than a researcher's. Noticing this was an important development in the way I then approached the interviews. This led me to begin the interviews with a formal statement regarding my intention to gather information relating to the under-researched phenomenon and that my role was a researcher and not a "fellow psychologist". I also had to explain that I would ask probing and clarifying questions, as my analysis required accounts to ensure the credibility and trustworthiness of the findings. I felt that this "set the scene" for my role as a researcher aiming to gather data relating to team formulation.

I also wondered how my questions may be received by participants, particularly as they were aware of my position as a trainee clinical psychologist. Will the psychologists feel they need to justify their practice? Will the other attendees of the team formulation perceive me as being judgmental of their practice? When introducing myself to participants, I thought it might be beneficial to outline my interest in this study was to gather their perceptions of their experiences, specifically outlining the limited research on this topic. I hoped that this would

enable participants to feel their reports would be valued and may challenge potential beliefs of being judged. This was also aimed at building a rapport with the participants by identifying them as the 'experts of this experience', with the hope that this may also enable participants to be more open. In spite of this, I was aware that I could not avoid the fact that the teams may have perceived me as an 'outsider', and this may have influenced the data collection and the subsequent results found.

I found it challenging to set up the focus groups, particularly as staff members reported having very busy diaries. Arranging each focus group took up to a month in an advance. On three occasions the focus group were cancelled and rearranged as participants reported unforeseeable events, such as sickness. Following two months of attempting to arrange my first focus group, I arrived to find three of the four participants. It was reported that the fourth participant had to attend to an emergency and was unable to attend the focus group. The other participants stated that they wanted to participate in the focus group on that date as they had made time for it and it would be difficult to re-arrange for another two months. As I had read literature regarding studies that have used three participants, I felt confident to continue with the focus group as this number of participants could still mean the main aspects of focus groups could be experienced, that is, group interaction. In the subsequent focus groups, I experienced the same difficulties which resulted in undertaking focus groups with three participants. Although focus groups have been reported to be a quick and efficient way of obtaining data (Morgan, 1996), there does not seem to be literature relating to the potential difficulties and ways of dealing with unpredictable outcomes. In contrast to this, I felt that the individual interviews were less challenging and did not experience any difficulties in setting these up. I wondered if the psychologists were more motivated in participating in the study than their colleagues. However, the focus groups required commitment of a group of participants to engage at a particular time and this challenge was removed within the interviews.

Transcription.

I decided to transcribe all of the recordings as in TA it is expected that 'immersion' into the data commences from transcription stage. During the focus groups I observed that some participants either confirmed or contradicted others' opinions by using non-verbal utterances. Therefore, I decided to include these, specifically laughter, in the transcriptions. I expected that transcribing three focus group recordings and three individual interviews would be time consuming and dull, but instead I found this an interesting process as it definitely assisted me in getting 'close and immersed' in my data. As I transcribed, this process also helped me remember the context of the data collection and remain grounded in the data.

Analysis stage.

Of all the research stages, I think this was the most time consuming and learning curve for me. As I had never used TA, I was worried that I would present findings that limited clarity and interpretative power. With the support of my research supervisors (MR & DDB) I believe I was able to maintain an inductive, mid range semantic and latent analytic approach, grounded within the data. During the analysis stage I recall referring to post it notes with the following questions, where does the unit of talk start and end? What is the core meaning of this extract? Is there anything else going on? And importantly, where is the evidence for this? In the focus group data I also asked myself 'How the participants were interacting? Are they agreeing with each other etc? I believe that this method of analysis enabled me to be inductive as I was immersed in the data. Furthermore, one focus group and one interview transcript were independently coded by the research supervisors (MR & DDB). This was incredibly useful in considering other interpretations and explanations of the data. In line with my critical realist position, I was aware that no research was conducted in a vacuum and as I had previous knowledge of the phenomenon this could lead me to focus on certain aspects of the data at the expense of others. Even so, I expect some 'truth' would have been found in this study's findings.

Following the analysis I was surprised by the themes that emerged in this study, in particular that attendees of team formulation (i.e., psychologists' MDT colleagues) did not report on the psychological aspects of team formulation. The findings identified that attendees gained a range of helpful and unhelpful aspects of team formulation influenced by a number of factors and processes, whereas there was no mention of psychological understanding. This contradicted with professional documents expecting team formulation to broaden psychological understanding (e.g., DCP, 2011, Onyett, 2007). I wondered if this was being 'unconsciously gained' by attendees, without them 'noticing' or recognising this, or whether this was not an important aspect of the process. This made me reflect on the powerful influence of professional documents published within the DCP, which appear to have driven clinical psychologists to be involved in team formulation on a basis of increasing MDT members' psychological understanding and knowledge. I considered whether the promotion of team formulation as a unique contribution of clinical psychologists was a reflection of the fragility of the profession within the mental health system. Is the clinical psychology profession still struggling to "find its place" and to be recognised within the mental health system? Literature on the profession of clinical psychology identifies the fragile status this profession has had over time, particularly in justifying its presence against dominant disciplines such as psychiatry and also competing psychology disciplines including counselling psychology (e.g., Pilgrim & Treacher, 1998).

Writing up.

During the write up of the report, I found this process challenging as I was working with a large amount of data. Numerous decisions were made regarding which data to include and which data to omit. I felt a sense of wanting to give justice to all the participants' reports, but balancing this by answering the research questions. My research supervisors supported me by checking drafts of work and giving me feedback. This was particularly useful as this was my first experience in writing up a research study. Alongside my research supervisors' feedback, I utilised an audit trail to ensure that the write up was representing the

participants' perceptions; however, I am aware that I inevitably had an important influence over this. In spite of this, I believe that this would have complemented the findings and that these would still present something of reality regarding CMHTs' perceptions of team formulation.

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APPENDICES



Schedule of Questions

(Final Version 1.0: 01.09.13)

- Describe to me what happens in your formulation meetings/ team formulation? How are they run? Who usually attends these meetings?
- As we are discussing about formulations, how you would describe what a formulation is?
- In the meetings that you have attended, have you found that some formulations are helpful and not helpful? Can you give me an example?
- What made the formulation helpful or unhelpful?
- What do you think led you to think that formulation was helpful and/ or not helpful?
- How did these formulations affect your clinical practice? What actually happens after the formulation meetings/ team formulation?
- Why do you think you get the results you do following the formulation meeting/ team formulation?
- What things or factors may have affected the use of the formulation?
- I wanted to find out about your perceptions about formulation meetings/ team formulation. Is there anything that we missed? Is there anything you came wanting to say that you didn't get the chance to say?

Appendix C



Topic list

- Formulation meetings/ Team formulation
 - What happens? Who attends?
- The formulations
 - Your description of this
 - Helpful or unhelpful formulations
 - What made them helpful or unhelpful?
- Effect on clinical practice
- Reasons for effect on clinical practice/ Factors that influenced this
- Anything that we missed or that you came wanting to say that you didn't get the chance to say?

Appendix D
Clinical Psychologists' Demographic Information Form

(Please check the boxes, if the statements apply)

Gender: ☐Female

☐Male

Age: ☐18-24

☐25-30

☐31-40

☐41-50

☐51-60

☐61+

How many years have you been working as a clinical psychologist?

.....

What opportunities have you shared psychological formulations with your MDT colleagues?

.....

Since qualifying, have you had training regarding team formulation or formulation meetings?

☐No

☐Yes

If yes, please give a brief summary of what this consisted of?

.....

.....

.....

.....

Thank you for taking the time to complete this form.

Appendix D

Focus group participants' Demographic Information Form

(Please check the boxes, if the statements apply)

Gender: ☐Female

☐Male

Age: ☐18-24

☐25-30

☐31-40

☐41-50

☐51-60

☐61+

Profession (please state)

.....

How long have you been working in the NHS?

.....

Please describe the service you work for? (E.g. assertive outreach, early intervention etc.)

.....

How long have you been attending formulation meetings/team formulation?

.....

When was the last time you attended a formulation meeting/ team formulation?

.....

Have you had training about formulations or any psychological theories?

☐Yes

☐No

If yes, please give a brief summary of what this consisted of?

.....

.....

.....

Thank you for taking the time to complete this form.

Appendix E

Participants' Demographic information

Psychologists		
Gender	Male	2
	Female	1
Age range	31-40	1
	41-50	2
Years in employment	0-10 years	1
	11-20 years	2
Training in undertaking team formulation	Yes (conference)	1
	No	2

MDT colleagues participating in the focus groups		
Gender	Male	3
	Female	6
Age range	31-40	3
	41-50	2
	51-60	4
Profession	Community psychiatric nurse	7
	Occupational therapist	1
	Support time recovery worker	1
Service	Community Mental Health Team	3
	Assertive Outreach	4
	Early intervention	1
Years in NHS employment	< 5years	1
	6-10 years	0
	10-15 years	2
	16-20 years	3
	21-25 years	1
	26-30 years	1
	31-35 years	1
Length of time attending team formulation	< 1year	1
	1-5years	2
	6-10years	4
	11-15years	2
Psychological (1 module) Training	Yes	2
	No	7
Last attended team formulation	< 24hours	1
	1- 2 weeks	1
	>2 week to <1month	1
	>1month to < 6months	6

Appendix F

Clinical Psychologists' Information Sheet

Title of Study: Shared Formulation and their Influence on Clinical Practice

What is the study?

The study aims to gather information regarding perceptions of team formulation also known as formulation meetings and shared formulation.

Why is it important?

There is limited information within literature about team formulation/ formulation meetings/ shared formulation and their impact on clinical practice. The study aims to broaden knowledge of an under-researched area.

What will taking part involve?

Prior to taking part in this study, you will be asked to read through the information sheet. If you are willing to take part, you will be requested to complete an informed consent and demographic form. The researcher will request you to distribute the study's flyer, information sheet and informed consent form to your multidisciplinary colleagues, regarding a focus group they are invited to attend. If up to five staff members confirm their consent to take part in the study, the researcher will arrange a date for the focus group. You will not be required to take part in this focus group. Instead, you will be requested to take part in an interview. An alternative date will be arranged with you and you will be contacted by the researcher to confirm your attendance. The interview is likely to last an hour. Following this, no further meetings will be arranged with you regarding this study.

Do I have to take part?

No, if you do not want to take part in the study, you do not have to.

What will happen to the recorded information?

You will be reminded that you have the right to withdraw from the study, 24 hours after the recording of the interview. If no contact has been made during this time period, the researcher will begin to transcribe and analyse the

information. No identifiable information will be included in the transcripts and you will be given a pseudonym to preserve anonymity. This will also ensure that you will be unidentifiable to your colleagues, so what is discussed during the interview does not comprise your working relationships with them. The transcripts will be stored on an encrypted (password protected) USB memory stick. Following transcription, the audio recordings will be deleted.

What will happen to my personal details on the forms?

Any personal details gathered will be kept confidential, in a locked filing cabinet, in the University of Lincoln. The information will be kept in the university for seven years before it is securely destroyed.

What will happen to the results after the study ends?

The results will form part of a doctoral thesis that the researcher is undertaking, and may be included in academic publications such as journal articles, posters or conferences. Your personal details (name and contact details) will not be used in these publications. If you would like to receive a summary of results of this study, you will have to confirm this on the optional form attached to the informed consent form.

How do I take part?

If you would like to take part, please sign the consent form and send this to the email address stated below. If you decide that you did not want to take part in this study, the information gathered will not be added to the study. Please ensure that you do state this within 24 hours after the recording of the interview. It will not be possible to withdraw the information after this time period.

What if I have any concerns or queries?

If you have any concerns or queries, please contact the researcher on the following details: tine.blee@nhs.net

Thank you for taking the time to read this information.

Appendix G

Focus group Participants' Information Sheet

Title of Study: Shared Formulation and their Influence on Clinical Practice

What is the study?

The study aims to gather information regarding perceptions of team formulation also known as formulation meetings and shared formulation.

Why is it important?

There is limited information within literature about team formulation/ formulation meetings/ shared formulation and their impact on clinical practice. The study aims to broaden knowledge of an under-researched area.

What will taking part involve?

Prior to taking part in the focus group you will be asked to read through the information sheet. If you are willing to take part in the study, you will be requested to complete the informed consent and demographic form and to send these to the researcher's secure email. Following this, a date will be arranged and you will be contacted by the researcher to confirm your attendance to the focus group. The focus group is likely to last an hour. Following this, you will not be required to attend any meetings about the study.

Do I have to take part?

No, if you do not want to take part in the study, you do not have to and are not obliged to.

What will happen to the recorded information?

Following the recording, the researcher will remind you that you have the right to withdraw from the study 24 hours after the recording. If no contact has been made during this time period, the researcher will begin to transcribe and analyse the information. No identifiable information will be included in the transcripts and you will be given a pseudonym to preserve anonymity. This will also ensure that you will be unidentifiable to your colleagues, so what is

discussed during the focus group does not comprise your working relationships in the team. The transcripts will be stored on an encrypted (password protected) USB memory stick. Following transcription the audio recordings will be deleted.

What will happen to my personal details on the forms?

Any personal details gathered will be kept confidential in a locked filing cabinet in the University of Lincoln. The information will be kept in the university for seven years before it is securely destroyed.

What will happen to the results after the study ends?

The results will form part of a doctoral thesis that the researcher is undertaking, and may be included in academic publications such as journal articles, posters or conferences. Your personal details (name and contact details) will not be used in these publications. If you would like to receive a summary of results of this study, you should confirm this on the optional form attached to the informed consent form.

How do I take part?

If you would like to take part, please sign the consent form. If you decide that you did not want to take part in this study, the information gathered will not be added to the study. Please ensure that you do state this within 24 hours of the day of the recording. It will not be possible to withdraw the information after this time period.

What if I have any concerns or queries?

If you have any concerns, or queries, please contact the researcher on the following details: tine.blee@nhs.net

Thank you for taking the time to read this information.

Appendix H
Consent Form
(Final Version 1.0: 01.09.2013)

(Please check the boxes, if the statements apply)

- ☐ I have read and understood the information sheet regarding the study and have requested further information, when needed.
- ☐ I understand that my participation is voluntary and I am free to withdraw from the study, without giving any reason. This will be applicable within 24 hours from the day of recording. If I have not stated my withdrawal during this period of time, I understand I will not be able to withdraw my participation from the study.
- ☐ I give permission to the researcher to contact me to confirm my attendance for the recording and to be audio recorded.
- ☐ I understand that the audio material will be used for transcription. If I do not contact the researcher during the 24hour period after recording, the researcher states transcription of the recordings will begin. No identifiable and personal information will be part of this and the recordings will be deleted following transcriptions.
- ☐ I am also aware that transcribed information will be kept safe and secure on an encrypted USB (password protected) memory stick. Any personal information gathered will be stored securely in the University of Lincoln, in a locked filing cabinet for 7 years.

☐ I agree to take part in the study

☐ I do not want to take part in the study

Participant's Name.....

Participant’s contact details (to confirm attendance after date and venue has been arranged)

Signature.....Date.....

Optional:

Would you like to receive a summary of results after completion of the study?

☐No

☐Yes

If yes, please write your contact details below, indicating where you would like the researcher to send the summary of the results:

.....

.....

.....

Appendix I

University of Lincoln Ethical Approval

RE: TineBlee Ethical Approval Form

Page 1 of 2

RE: TineBlee Ethical Approval Form

Patrick Bourke

Sent: Monday, September 16, 2013 10:31 AM

To: Tinemakomboreroashe Blee (12354170)

Hi Tine,

I can't see any contentious ethical issues arising out of what you propose and am happy to give ethics approval by Chairs Action.

Please take this email as formal approval. Should you require this in some other form later, that can probably be organised.

All the best,

Patrick Bourke

Chair Soprec (School of Psychology Research Ethics Committee)

From: Tinemakomboreroashe Blee (12354170)

Sent: 15 September 2013 23:27

To: Patrick Bourke

Subject: RE: TineBlee Ethical Approval Form

Importance: High

Hi Patrick,

Thank you for your feedback. I have added a section in the form outlining what will be discussed with the participants. This is found in the study design section, after discussing the interviews with the clinical psychologists. Please let me know if this is clearer or if you would require further clarification.

Kind regards,

Tine

Trainee Clinical Psychologist
Trent Doctorate in Clinical Psychology

From: Patrick Bourke

Sent: Friday, September 13, 2013 5:57 PM

To: Tinemakomboreroashe Blee (12354170)

Subject: RE: TineBlee Ethical Approval Form

Hi Tine,

I've taken a preliminary look over our application to see if it could be processed by our Track A system, where applications can be approved by Chairs action.

If you can clarify what exactly the participants will be asked to discuss, I may be happy to do this ?

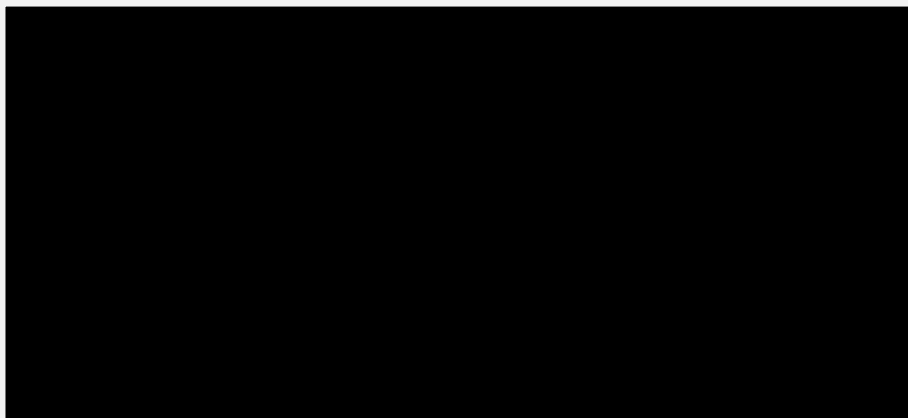
Thanks,

Patrick



<https://email.lincoln.ac.uk/owa/?ac=Item&t=IPM.Note&id=RgAAAABsDO6iZpfvQa...> 03/10/2014

Appendix J
R & D NHS Approval documents



Brayford Pool, Lincoln
LN6 7TS

4 November 2013

Dear Tine,

Letter of access for research with [REDACTED]
[REDACTED] or Study Ref – *M00573 Shared formulations and their
influence on clinical practice*

This letter confirms your right to conduct research through [REDACTED]
[REDACTED] for the purpose and on the terms
and conditions set out below. This right of access commences on **4 November
2013** and ends on **30 September 2014** unless terminated earlier in accordance
with the clauses below.

As an existing NHS employee you do not require an additional honorary research
contract with [REDACTED] is satisfied that the research activities that you will
undertake in the organisation are commensurate with the activities you undertake
for your employer. Your employer is fully responsible for ensuring such checks as
are necessary have been carried out. Your employer has confirmed in writing that
the necessary pre-engagement checks are in place in accordance with the role you
are to carry out in [REDACTED]. Evidence of checks should be available on request to
[REDACTED]

You have a right of access to conduct such research as confirmed in writing in the
letter of permission for research from [REDACTED]. Please note that you cannot start the
research until the Principal Investigator for the research project has received a
letter from us giving the organisation permission to conduct the project.

You are considered to be a legal visitor to [REDACTED] premises. You are not entitled to
any form of payment or access to other benefits provided by [REDACTED] to emp [REDACTED]
and this letter does not give rise to any other relationship between you and [REDACTED]
or this organisation, in particular that of an employee.



HQ Elizabeth House, Fulbourn Hospital, Cambridge CB21 5EF.
T 01223 726789 F 01480 398501 www.cpft.nhs.uk
Page 1 of 3
A member of Cambridge University Health Partners

While undertaking research through [REDACTED] you will remain accountable to your employer **Lincolnshire Partnership NHS Foundation Trust** but you are required to follow the reasonable instructions of your nominate [REDACTED] in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by [REDACTED] or this organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with [REDACTED] policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with [REDACTED] in discharging its duties under the Health and Safety at Work etc. Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on [REDACTED] premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and [REDACTED] prior to commencing your research role at each site.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.


[REDACTED] will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that [REDACTED] accept no responsibility for damage to or loss of personal property.

This letter may be revoked and your right to attend [REDACTED] terminated at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct.

or to be disruptive and/or prejudicial to the interests and/or business of the organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the organisation that employs you through its normal procedures. You must also inform your nominator 

Yours sincerely



Cc





Date of NHS Permission: 14th January, 2014

Miss Tinemakomboroashe Blee
Trainee Clinical Psychologist
Lincolnshire Partnership Trust
University of Lincoln
Faculty of Health, Life & Social Science
1st Floor, Bridge House
Brayford Pool
Lincoln
LN6 7TS

Dear Miss Blee,

Study Title: Shared Formulations and their Influence on Clinical Practice

Sponsor: University of Lincoln

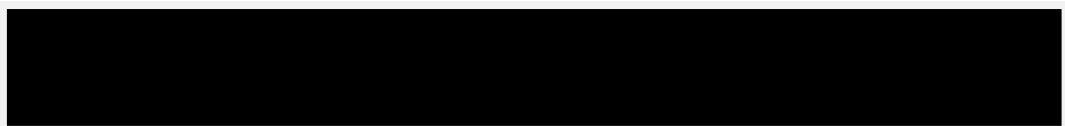
Academic Supervisor: Dr Michael Rennoldson

Thank you for submitting your project to the [REDACTED] I&D Department. The project has now been given NHS permission for POC activity on behalf of [REDACTED]

NHS permission for the above research has been granted on the basis described in the application form, study protocol and supporting documentation. The following documents were reviewed:

Document	Version	Date
Invitation Letter	1	01/09/2013
Participant Information Sheet	1	01/09/2013
Focus Group and Interview Questions	1	01/09/2013
Demographic Information Form	1	01/09/2013
Study Protocol	1	01/09/2013
Consent Form	1	01/09/2013

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP [ONLY if applicable], and NHS Trust policies and procedures available [REDACTED]



The research sponsor or the Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The R&D Office should be notified within the same time frame of notifying the REC and any other regulatory bodies. All amendments (including changes to the local research team) need to be submitted in accordance with guidance in IRAS.

Please note that the NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research.

Yours Sincerely

A black rectangular box redacting the signature of the research sponsor.

CC.

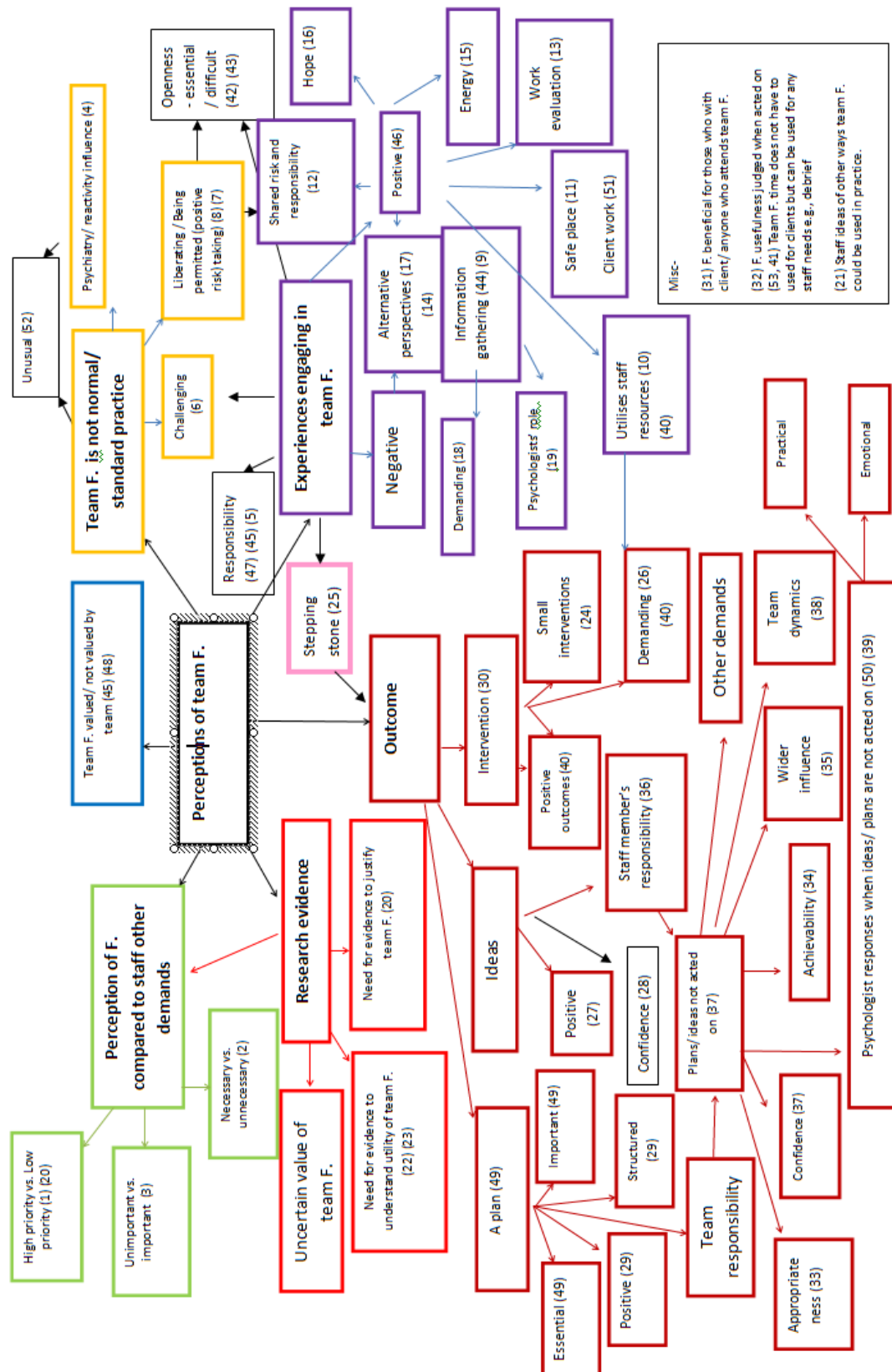
Sponsor

Appendix K

Meaning of Transcription conventions

Symbol	Use
[text]	Indicates the start and end points of overlapping speech.
=	Indicates the break and subsequent continuation of a single interrupted utterance.
(.)	A brief pause, usually less than 0.2 seconds.
((<i>italic text</i>))	Annotation of non-verbal activity e.g., ((<i>laugh</i>)) ((<i>cough</i>))
...	Data not presented in the paper due to its irrelevance to the analysis
[pseudonym]	Changing identifiable information
‘ text ‘	Indicates when participant uses a different tone of voice to describe a past event.
-	Indicates person stopped in mid-sentence.

Initial thematic map



Appendix M

Early stages thematic table

Perceptions of team formulations. on clinical practice			
Overarching themes	Sub-themes	Underlying themes	
Perceptions of team formulation	Comparison with other demands	Low priority but wishes for higher priority	
		Job insecurity	
	Roles and responsibilities	Undertaking its demands: A choice or responsibility	
		Responsibility	
	Value	Unawareness/ Uncertainty of the impact of team F.	
		Research needs for Justification	
Process	Disclosing 'stuckness'	Safe and Protected Forum	
		Increased vulnerability/ Threatening	
		Inconsistent with psychiatric way of working.	Stops work re: reactivity/
			Pathologising

	Information gathering	Examination of clients' history	
		Staff pressured	
		Anxiety regarding limited information	
		Irrelevant information	
	Shifted/ Broadened understanding	Individual and shared understanding	
		Challenged perspectives	
		Psychological thinking	
		Turning point	
	Emotional processing	Validation	Individual validation
			Multiple validation
		Emotional understanding	
	Challenged risk management	'Positive Risk Taking	
		Support for 'risk taking'	Requirement
			Shared responsibility
Outcome	Choice to implement F.	Depends on care-coordinator	

	ideas	Out of staff control	
		Achievability of ideas: Impasse (Deal-breaker)	Overwhelming ideas
			Care plans
	Care plans	Justification of team formulation	
		Individualised and appropriate plan.	
		Alternative ways of working	
		A intervention plan vs. A plan of ideas	Choice implications/ Immediacy
		Unimplemented ideas	Psychologists' conflicting emotions
			Perceived wasted time
		Implemented ideas	Client engagement
			Turning point
		Care plans not revisited	

Appendix N

Sample Analysis 1: Focus group data

Mod: ok (.) have you got examples where it hasn't been useful

P2: I think in our team we have had a change of consultant in the team I think in the past the consultant perhaps I'm speaking out of terms (.) but the consultant in the past would have been more keen on the formulations

P1: =yeah yeah ((nodding his head))

P2: = I think we have had situations I've certainly had situations where I have formulated a client and sort of (.) discussed this with the consultant and the consultant has perhaps dismissed that formulation and you can feel quite powerless in that situation but you sort off power ahead regardless (.) I don't know if that fair really

P1: = I know what you are saying (.) I mean as (P3) was saying earlier (.) it has to have all the people buy into the idea of formulating and (.) it involves risk

Comment [D1]: P1 reinstates what P3 regarding team formulation involving risk.

P2: =I was going to say it involves risk doesn't it (.) because information can often help you take therapeutic risk with people can't it (.) but then if you have someone else coming in and saying actually do you know what I'm not prepared to take any risks then I think that formulation can go out of the window
(((laughter)))

Comment [D2]: P1 and P2 agree with each other regarding the challenges of team members not supporting ideas that may be risky

P1: [yeah yeah absolutely] =if you do have people that are risk adverse and do all they can to prevent you from taking any risks (.) then it pretty much squashes it doesn't it

Comment [D3]:
Current consultant has been less keen on team formulation (team F.)
When team F. had not been supported (by consultant) this had led staff to feel 'powerless'.
Consultant's perceptions of team F. may impact on staff confidence regarding team F. (Latent).
Team F. does require support from all staff members to be acted upon (latent).
Staff believe that team F. assumes that all staff are supporting another staff member to take a risk.
Team F. ideas are not acted on if they are not supported by others in the team.
Team F. ideas are not acted on if other staff members are reluctant to take some responsibility on the risk attached to these.
Team F. challenges the way psychiatric staff manage risk.
Professionals from a psychiatric background may find it difficult to take risks using F. as they aim to minimise these.
Team F. goes against others way of working (latent)

Mod: so something about that anxiety as well (.) about you going to do something about it (.) if someone else has said 'oh I'm not sure about that'

P2: =yeah if you take things from a psychiatric view (.) it sounds like I'm just criticising doctors but I am not trying to ((laughter)) (.) it can very much- it can be quite erm (.) anxiety provoking to take risks because it's very much about (.) if someone is presenting in such a way we need to medicate that person we need to perhaps get them to hospital (.) whereas you can formulate and come up with an idea to allow that person to-to- take a risk-

Appendix N: Sample Analysis 2: Individual Interview Data

P1: [in AO we have a slot in weekly team meeting we have a slot where in our weekly team meeting we have an extended case discussion after the main (.) business clinical meeting and that is where we do the formulations in AO (.)] and that can be productive but again will be derailed by firefighting (.) you see a theme ((laughter))

Comment [TB1]: FM organisation/ set up

Comment [2]: FM can be unstable
F. do not always run as they should.
F. is affected by psychiatry way of managing cases.

Int: yeah (.) can you tell me more about this derailing (.) how does that occur

P1: [think it comes down to the fact that psychological approaches across the border are still considered a luxury in mainstream in adult mental health care erm (.) the justification for them is completely appreciated in one to one therapeutic basis and increasingly staff are feeling able to deliver baseline psychological interventions with support erm (.)

Int: mmh

P1: erm (.) unfortunately the (.) if you like the team ethos doesn't have the psychological as well entrenched in it as the psychiatric (.) so when crises come up there is default towards a psychiatric model of care which lends itself much better to crisis management than a formulation model because you need time and you need space (.) and when people are under pressure they don't often think about allocating their time to thinking they are too busy responding (.) how being a psychologist I would say its always better to stop and think about what you are doing before rushing out there and doing it but with one voice within a group of eight nine ten individuals (.) that's one voice advocating stopping thinking planning and there is nine individuals who are busy running and that's often the challenge (.)

Comment [TB3]: Team F is not justified compared to 1:1 F.
Staff are accustomed to the psychiatric model.
Psychiatric model is more influential in staff work than F. psychology.
Psychiatric model does work better in some aspects of staff work than F. model.
F. is not standard practice.
F. is seen as an additional demand.
Its challenging to introduce F. in teams.

Comment [TB4]: Psychologist believes he is the sole advocate for F.

POSTER

Outcomes of Team Formulation: Community Mental Health Professionals' Perceptions

¹Tinemakomboreroashe Blee, ²Michael Rennoldson, ²Danielle De Boos, ¹Sharron Smith

¹College of Social Science, University of Lincoln, UK

²Institute of Work, Health and Organisation, University of Nottingham, UK

Introduction

Team formulation is a process where multidisciplinary team members contribute to the development of a psychological formulation¹. Team formulation is expected to support professionals to (1) work effectively with their clients, (2) meet their clients' needs and (3) broaden their psychological knowledge. There is a lack of research exploring these expected outcomes in detail within Community Mental Health Teams (CMHTs).

Research Questions

Question 1: What are considered helpful or unhelpful aspects of the outcomes of team formulation?

Question 2: What factors influence the outcomes of team formulation?

Method

12 CMHT members who attended team formulation were recruited from three sites within the British National Health Service. An individual interview was undertaken with a clinical psychologist and a focus group with three professionals was conducted in each site. An inductive, mid-range semantic and latent, thematic analysis was used to analyse the data.

Results: Question 1

Across all transcripts participants reported that ideas derived from team formulation integrated into care plans (CPs) were integral and valued outcomes of team formulation.

Across all teams participants reported that CPs were helpful in:

- Justifying attendees' engagement in team formulation,
- Prioritising and making ideas achievable
- Providing a rationale for professionals to test ideas, most appropriate for clients' needs.

Participants did not report unhelpful aspects of CPs.

Results: Question 2

There were conflicting perceptions across the teams regarding the factors that influenced the use of CPs, which included:

- Psychologists reported that CPs should be used and also that this was not required as attendees adopted alternative perspectives; whereas attendees only reported the latter.
- Differing expectations of CPs as either "intervention plans" or "lists of ideas"
- CPs viewed as a concluding rather than ongoing task.
- Care-coordinators perceived as the decision makers in the use of CPs.
- Responsibility for using CPs perceived as held by either the care-coordinators or the whole team.
- Service restrictions in enabling professionals to use CPs

Study findings and Expected Outcomes

This study findings identified that team formulation met two out of three of the expected outcomes¹. Participants reported that CPs enabled them to work effectively with their clients and helped meet clients' needs. Attendees did not report broadened psychological knowledge following team formulation.

Conclusions

This study provided novel findings regarding the integral and valued aspect of CPs within team formulation.

This research suggests that each CMHT should agree on their expectations of the outcomes of team formulation i.e., is it when professionals use CPs, adopt alternative perspectives, or both.

If CPs are to be utilised then CMHTs may require the support from their managers.

References

1. Division of Clinical Psychology (2011). *Good Practice Guidelines on the use of psychological formulation*. Leicester: British Psychological Society.

Summary of Service-Related Research and associated Impact (SSRI)

Summary of Service-Related Research and associated Impact (SSRI)

Trainee(s)	Supervisor(s)	Placement	Cohort	Date Completed
Tinemakomboreroashe		Learning	2012	July 2014
Blee		Disability		

Research background and context

Challenging behaviour (CB) is defined as ‘culturally abnormal behaviour(s) of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to ordinary community facilities’ (Emerson, 2001, p. 3). Individuals with learning disabilities (LD) are three to five times more likely for their behaviours to be interpreted as CB than the general population (e.g., Poppes, der Putten, & Vlaskamp, 2010). CB is therefore a major concern for a substantial number of people with LD as it can result in placement (living arrangement) breakdown (e.g., Broadhurst & Mansell, 2007; Joyce, Ditchfield & Harris, 2001; Lowe, Felce & Blackman, 1995; Phillips & Rose, 2010).

This audit was undertaken in a specialist CB service which was established in October 2010. The development of this service was in line with the Commissioning Specification for Crisis Intervention Assertive Outreach services which aims to reduce inpatient unit admissions and high cost placements resulting from placement breakdown (Eccles, 2009). This is in accordance with the Valuing People Now document which aims to enable people with LD to

receive services in the community at or close to their homes, enabling social inclusion and integration with mainstream services (Department of Health, 2009). As the service had recently been developed, the service manager and my placement supervisor were keen to evaluate the processing of the referrals accepted within the service in order to ascertain if these met the referral criteria outlined within the Commissioning Specification.

Research aims

An audit was undertaken to assess referrals accepted by a specialist service that provides psychological support to adults with LD who display CB. The service manager and my placement supervisor were keen to assess the proportion of referrals that met the criteria outlined within the services' Commissioning Specification. Clients that are supported by this service had to meet the initial criteria in that they had to be registered in the county catchment area and have a LD. Following this, clients had to present with any of the following needs:

- a) Behaviours that do, or are likely to pose a risk to self or others.*
- b) Increased accidents or incidents within their current care setting.*
- c) A potential placement that is at risk of breaking down or has already broken down.*
- d) Whose admission to a mental health or learning disability inpatient unit is being considered, or may otherwise be required.
- e) Who it has not been possible to identify or implement appropriate methods of intervention and support for.
- f) Who are difficult to engage with LDCP and mental health services.

The service manager and placement supervisor outlined that Criterion 1a to c could be easily operationalised and quantified and therefore agreed that these would be the assessed. It was agreed that Criterion 1a and b could be grouped as 'Challenging Behaviour (CB)' and Criterion 1c could be reported as 'Placement Breakdown (PB)'. The rest of the criteria (Criterion 1d to f) were disregarded for this audit due to difficulty in operationalising and quantifying

these. The focus of the audit was therefore to assess if referrals were accepted if clients were registered in the county, had a LD and CB and/ or were at risk of a PB.

If referrals did not meet the criteria, the service manager and my placement supervisor were interested in how these were processed and dealt with. The report also outlines the stages in which clients were discharged from the service and the reasons for this.

What the research discovered

Following the referral meetings for this service, it was agreed that I would be able to access the list of the recently discharged clients. Following this, I would access clients' electronic notes and collect data relating to their care pathway when supported within this service. A total of 50 cases were assessed.

The current audit identified that 58% of the cases assessed met the initial referral criteria as clients were resident within the county and had a LD. Of those 42% who did not meet the initial referral criteria, it was found that 57% (N= 12 of 21) of these clients continued to receive treatment within the service. This raised questions regarding the initial assessment of clients when referrals are processed within the service. In particular information regarding clients' severity of their LD did not appear to be gathered for 40% of the clients.

The audit identified that approximately 83% of the cases showed clients presenting with CB and/or PB. It was interesting to find that of the 17% who were referred to the service despite not presenting with either CB or PB, 40% (2 of 5) of these clients continued to receive treatment from the service, particularly relating to staff training. This intervention did not appear to match clients' severity of their presenting difficulties; although it could be argued that these difficulties may be related to other criteria that could not be assessed within this audit due to difficulties in operationalising these.

The results further showed that the service provided intervention to approximately 31% of clients who met the initial referral criteria. The rest of the clients were discharged during the initial and assessment stages (i.e. referral, observation and triage). This indicates that at times these stages provided good opportunities to comprehensively assess clients' difficulties and ensure appropriate service intervention.

How the findings will be disseminated

The findings were discussed with my placement supervisor and service manager who decided that they would hold a meeting with the team manager of the service.

Service impact achieved by the research and future plans

The following recommendations were discussed with the service manager and placement supervisor:

- Consideration of how staff members initially assess clients regarding whether they live within the catchment area or have a LD needs to be explored. It would be beneficial for thorough information gathering to be undertaken during the referral stage which could be enabled by completion of a comprehensive referral form. A system could be put in place in which referrals that are not adequately completed could be returned to the referrer to ensure thorough information gathering as this stage. If this was to be ensured then this could prevent clients who do not meet the referral criteria to be further assessed within the service.
- With regards to information such as clients' LD status that is unknown to the referrer, the service may need to consider a trained staff member/s to administer a validated short-form battery cognitive assessment to assess individuals with LD. However this would require an in-depth discussion with the service managers and potentially the commissioners to weigh up the potential cost of time and further training in order to ensure that team member/s have this skill set. However, as indicated earlier this may lead to

an ethical, moral and financial debate of this practice. This would need to be looked into as the service is particularly commissioned to support individuals with LD.

- Overall, the service may benefit from an explicit screening procedure in order to ascertain individuals whose referrals may be accepted. Earlier in this report, I indicated that the Commissioning Specification referral criteria did pose difficulties in ascertaining the presenting difficulties that would need to be considered in order for a referral to be accepted. Therefore aspects of the criteria had to be disregarded for the purposes of ensuring operationalisation and quantification. For example, it was not clear what Criterion 1e entailed regarding clients who have difficulties in engaging with LDGP and mental health services. How would engagement be assessed? What difficulties would need to be presented to meet this criterion? If service managers intend to use the criteria outlined within the Commissioning Specification then it would be beneficial for these aspects (particularly criterion 1d to f) to be explicitly detailed in order to ensure that understanding and easy identification of referrals that meet these criteria. Referrers could be requested for this information during the referral stage and questions relating to these aspects could be asked within the referral form e.g., Criterion 1d states clients whose admission to a mental health or learning disability inpatient unit is being considered or may otherwise be required. In the referral form questions relating to this may be outlined such as has admission to a mental health or inpatient unit being considered? If so, what was the context of this potential decision?

In conclusion, the service aims to assess the referrals accepted provides a resource-efficient way of ensuring that they are meeting criteria outlined by their Commissioners and the demands of their client group. These results are hoped to continue to shape the service development over time.

Trainee's Signature: Tinemakomboreroashe Blee **Date:** 6.8.14

Supervisor's Signature: [REDACTED] **Date:** 1.9.14

Supervisor's Signature: [REDACTED] **Date:** 4.9.14

Module Convenor Signature: Dr David Dawson
(Approved by email) **Date:** 6.8.14